

The Perceptions of Kinesiologists of Ethics and Professionalism as Established by
the College of Kinesiologists of Ontario

Chad Denyes, Honours BSc. Kinesiology

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Supervisor: Danny Rosenberg, Ph.D.

Faculty of Applied Health Sciences
Brock University
St. Catharines, Ontario

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Abstract

As of April 1, 2013 kinesiology became a regulated health profession in Ontario. With its own governing body, the College of Kinesiologists of Ontario (CKO), there are new ethical and professional standards to which kinesiologists must adhere. The purpose of this study is to investigate kinesiologists' thoughts and perceptions regarding the CKO's Practice Standards, Guidelines and Code of Ethics, and their level of ethical knowledge and training. Eleven semi-structured interviews were carried out with kinesiologists. Interview data was analyzed through the development of general themes. Findings revealed that kinesiologists are confident of their ethical decision making skills but are in need of more ethical and professional education and training in order to become respected healthcare professionals in the healthcare community and in the eyes of the public. Furthermore, there were key areas identified in need of improvement regarding the quality of the Practice Standards, Guidelines and Code of Ethics. Additional findings, implications and recommendations for future research were also discussed.

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Chapter One

Overview

Introduction

The regulation of all health professions in Ontario is established through the Regulated Health Professions Act of 1991 (RHPA). In 2007, under the RHPA of 1991, the Kinesiology Act was passed, declaring that kinesiology would become a regulated health profession in Ontario (Kinesiology Act, 2007). Like all other regulated health professions, kinesiology, as of April 1, 2013, has a governing body to oversee each individual who becomes licensed as a kinesiologist. This agency is known as the College of Kinesiologists of Ontario (CKO). The 2007 Kinesiology Act mandated that the CKO would be the regulatory body for all kinesiologists practicing in Ontario (Kinesiology Act, 2007). This Act also appointed a Transitional Council to develop all the new professional standards, rules and guidelines of the College (Kinesiology Act, 2007). The practice standards describe what is considered professional misconduct. Guidelines provide more in-depth, practical information with the express purpose of making it easier for kinesiologists to understand the practice standards of misconduct. A formal code of ethics is now in place that kinesiologists should use to guide their practice. These various regulations support the mandate of the RHPA of 1991 which states, “it is the duty of the College to work in consultation with the Minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals” (Regulated Health Professions Act, 1991, schedule 2, 2.1).

The RHPA also states objectives to which Colleges under the provision of the RHPA must adhere. In reference to ethics and ethics knowledge, the RHPA asserts that

one of a College's objectives is "to develop, establish and maintain standards of professional ethics for the members" (Regulated Health Professions Act, 1991, schedule 2, 3). It is the duty of the CKO in particular, like every regulated health profession, to ensure that all certified kinesiologists possess a base of knowledge of professional ethics, and then establish and maintain that level of knowledge for practical use.

Scholars have addressed the subject of ethical development and maintenance within other healthcare professions besides kinesiology. For example, ethics education today begins early in medical school training and continues as a mandatory continuing education requirement throughout a physician's professional career (Bolin, Mechler, Holcomb, & Williams, 2008). Since the CKO has only been recently established there is no knowledge as to the level of ethical development and maintenance of kinesiologists. Other professions like nursing, however, have an extensive literature pertaining to their level of perceived knowledge about their ethical development and maintenance. Yet even in such an established profession, Doane and colleagues (2009) express a concern in stating that nurses felt they were lacking ethical knowledge when faced with certain ethical dilemmas like patient autonomy versus essential care.

To assist health professionals to remain ethically competent and knowledgeable, many Colleges have developed and implemented a code of conduct or a code of ethics. These codes are in place to safeguard College members and ensure practitioners maintain minimal professional standards (Nyika, 2009). This study will examine the code of ethics developed by the CKO that will guide the professional conduct of practicing kinesiologists (see Appendix K). In general, codes of ethics are put in place to provide ethical guidance for healthcare professionals, distinguish a common set of moral

principles to which the conduct of the professionals may be measured against, and provide the public with an outline of the type of behavior and knowledge that healthcare professionals should display (Kluge, 2011). Before elaborating on the code of ethics, I would like to describe a few key terms relevant to professional ethics and what it means to be a regulated health profession.

Professionalism is a term that is widely used and requires a clear description of the context in which it is used. Swick (2000) asserts that professionalism is a collection of behaviors that healthcare practitioners must uphold for the protection of their patients and the public. Some of these behaviours that best define professionalism include: acting ethically and adhering to moral and ethical standards, putting the interests of the patients above your own as you have the responsibility of looking after their health, demonstrating accountability for yourself and your colleagues, and being competent and developing competency through continuing education. These behaviors must be upheld by kinesiologists who are now part of a self-regulated health profession in Ontario.

As for clarifying what a profession is and what it means to be a profession, Hoffman (2009) lists a set of characteristics that must be met in order to be considered a major, rather than a minor, profession. These five characteristics are: mastery of complex skills that are grounded in and guided by systematic theory and research; the performance of services for others, known as clients or patients; being granted a monopoly by the community to supply certain services to its members; being guided by formal and informal ethical codes intended to preserve the health and well-being of clients or patients; and meeting the expectations and standards prescribed by one's professional subcultures. Kinesiologists are solely responsible for delivering a specific public service,

and therefore must uphold the professional and ethical standards set by their governing body (CKO) to ensure the safety of the public. See appendix G for a definition of professional standards.

Values are what underlie principles and help guide the way many people manage their lives (Beauchamp & Childress, 2001). The CKO uses a values-based approach in describing expected professional ethics and conduct. Values in healthcare are seen as a way of determining what is important, not only for patients, but for practitioners as well. Values provide a way of assessing each situation individually by considering what the patient may value most, rather than what research may disclose as a best method of approaching a situation. For example, one may have two patients in identical circumstances, but in order to act in the best interest of each patient one may provide different interventions or treatments for each patient because they do not share the same values (Fulford, 2011).

Morals (which will be used interchangeably with ethics throughout this thesis) is understood as “norms about right and wrong human conduct that are so widely shared that they form a stable (although usually incomplete) social consensus” (Beauchamp & Childress, 2001, p. 2). Morals are seen as set of normative thoughts and practices that govern good, ethical behavior. When people behave immorally, they go against what society considers is good ethical behavior, yet their conduct to them may still be ethical if it represents their values. For example, the behavior of physicians who engage in doctor-assisted suicide may be considered moral in some European countries but such behavior may be deemed immoral in Canada.

Principles in healthcare differ from values and morals. Principles are used as a framework for guiding practitioner's ethical practice and represent values that should be upheld in healthcare (Beauchamp & Childress, 2001). Ethical principles are general statements designed to provide practitioners with an idea of the important values within healthcare, but they may not delineate which values are more important than others and do not address specific complex situations (Winkler & Gruen, 2005). For example, in a situation where a patient's health is at risk and she or he initially refuses treatment, two conflicting principles, autonomy (self-determination) and beneficence (doing good), may be involved. In this case the physician treating the patient may weigh each of these principles before recommending several options in the patient's best interest.

Beauchamp and Childress (2001) refer to ethics as "a generic term for various ways of understanding and examining the moral life" (p. 1). More specifically, practical ethics looks at using theories and norms to evaluate moral issues in real life situations (as opposed to theoretical situations). There is no clear answer for all moral or ethical issues, but through the use of cases and real life examples, one can deduce how to address and resolve moral problems (Beauchamp & Childress, 2001). Ethics can provide tools or a yardstick for determining good and bad, right and wrong conduct. Moral philosophers have proposed and developed ethical theories to help make such determinations. For example, teleology or consequentialism focuses on ends like happiness and how actions either fulfill or fall short of such ends (Beauchamp & Childress, 2001). Deontology demands that one has a duty or obligation to act by abiding with universal truths like the Golden Rule with little or no regard for achieving certain consequences. This obligation

is dependent on what is considered moral, and not based on weighing consequences (Beauchamp & Childress, 2001).

With these key terms in place, a code of ethics provides health professionals with an outline to conduct their practice ethically, and gives them a framework for dealing with ethical issues (Canadian Nurses Association, 2008). Healthcare professions use codes of ethics as a means to inform their members of their moral responsibility (Beauchamp & Childress, 2001). A code of ethics also provides the public with an idea of the values that healthcare professionals should bring to every interaction with patients and clients. It serves as a tool for self-evaluation, allowing healthcare workers to assess how they should respond to future ethical issues and how they have responded to previous issues (Canadian Nurses Association, 2008).

Within the CKO's code of ethics, a values-based approach is adopted that also includes an ethical decision-making model. This model provides a step-by-step procedure for kinesiologists to follow to resolve ethical issues. Within this values-based approach are five principles of ethical conduct. The principles are: 1) respect, 2) excellence, 3) autonomy and well-being, 4) communication, collaboration and advocacy, and 5) honesty and integrity. Beauchamp and Childress (2001) view only autonomy as a principle; therefore one may assume the CKO Transitional Council who designed this standard perhaps understood principles and values interchangeably. The purpose of providing this information is to help kinesiologists determine the best course of action when dealing with ethical problems (Transitional Council, 2012).

Some of these values differ from what other healthcare systems in Canada and across the world use to deal with ethical situations. Across the world, health professions

base professional ethics around four major principles: beneficence, non-maleficence, autonomy and justice/equity (Beauchamp & Childress, 2001; Doane, Storch & Pauly, 2009; Westerholm, 2007). Littleton et al. (2010) add, “Healthcare ethics is based on moral principles developed from various ethical theories” (p. 31). The preceding researchers then go on to state that ethical issues are often so complex that current ethical theories are unable to adequately address many ethical problems. Pattison (2001) claims that within nursing codes of ethics in the United Kingdom there is a lack of ethical guidance. He asserts, “Instead, codes often exist at such an abstract and general level that they are open to being either misinterpreted or ignored” (p. 10). He continues further by saying, “If professionals cannot make sense of or apply codes to ethical issues, there is a real danger they will reject and neglect them altogether” (p. 11). Similarly, the reader of professional ethics codes usually finds no specific guidance in them when trying to address a particular ethical situation (Westerholm, 2007).

To learn more about the status of ethical knowledge and training among practicing kinesiologists, I attended the annual conference of the Ontario Kinesiology Association (OKA), the lobby and advocacy organization of kinesiologists, in October 2013. I was one of eight Master’s students selected to present their research in a poster presentation session. I attended several oral presentations delivered by kinesiologists and spoke with many kinesiologists at the conference. From these experiences I gained greater insight into what kinesiology is, how it is viewed by its members, and what sorts of issues and areas of uncertainty kinesiologists face. Although most kinesiologists I spoke to were registered members of the CKO, many were still unsure of what it meant to be registered and what their new professional status entailed. One person I spoke with

mentioned that he had difficulty determining the scope of practice in kinesiology and knowing when he was inside or outside the scope of practice. Another kinesiologist spoke of the difficulties in working in a hospital setting because she was uncertain of which code of conduct she should follow, the hospital's or the CKO's.

Various presentations that I attended discussed common problems that have arisen since kinesiology in Ontario became a regulated profession. For example, many kinesiologists know little about privacy rules and regulations, specifically regarding access to client health information and ownership of client records. Much of the professional conduct to which kinesiologists must adhere is not entirely new, but now, it is far more explicit, because it is expected that this conduct be known and that the legal onus and responsibility for healthcare services rest with kinesiologists themselves and not the organization or healthcare owner they work for.

The above discussion and my personal experience with kinesiologists at the OKA conference therefore revealed a need to explore what kinesiologists know about the code of ethics and other professional standards as established by the CKO, how useful such guidelines and the code of ethics are to kinesiologists, and how prepared their ethical training has made them to deal with ethical issues they face in their practice. The main purpose of this study then was to investigate kinesiologists' perceptions of ethics and professionalism as delineated by the CKO by interviewing several practicing kinesiologists in different workplace settings. As such, the following research questions were asked.

Main Research Questions

1. What changes would kinesiologists like to see in terms of ethical and professional training and development?
2. What do kinesiologists know or do not know about the ethical and professional standards of the CKO?
3. How useful is the CKO's code of ethics/code of conduct?
4. How prepared or unprepared are kinesiologists when dealing with specific ethical situations?

To answer the research questions, an interpretive paradigm was employed. Within this paradigm interpretive description (ID) was the methodology used to guide the research. ID was incorporated within the data collection and analysis stages. ID provides the researcher with flexibility when conducting interviews and in terms of discriminating and selecting relevant material from the data. It also allows for the generation of recurring patterns to emerge from the data. A qualitative document analysis (QDA) was also conducted to critique the CKO's standards, guidelines and code of ethics. These approaches along with the interpretive paradigm and QDA will be explained in greater detail in chapter two.

Rationale

As mentioned earlier, as regulated health professionals in Ontario, kinesiologists must now adhere to an increased level of responsibility and trust when it comes to providing competent and ethical care to the public. For this reason I elected to explore kinesiologists' thoughts and perceptions regarding ethics, particularly the practice standards, guidelines and code of ethics set forth by the CKO. It is important to

understand kinesiologists' views regarding these documents because the purpose of the latter is to provide legal and ethical guidance and discipline to those who may not be practicing competently and ethically. Therefore, I chose to conduct interviews as my method of data collection. Interviews are well suited for understanding and describing people's perceptions because they can tap into the meanings of lived experiences (Collingridge & Gantt, 2008). Liamputtong (2009) claims, "in-depth interviews aim to elicit rich information from the perspective of a particular individual and on a selected topic under investigation" (p. 43). Creswell (2013) states, "knowing some common experiences can be valuable for groups such as therapists, teachers, health personnel, and policy makers" (p. 82).

Examining the experiences of kinesiologists through interviews and drawing conclusions about these findings would be useful to other currently practicing kinesiologists and also the CKO who are responsible for registering kinesiologists. Sharing the results of this study may assist the CKO to modify its competency requirements and its practice standards and guidelines to help kinesiologists when faced with ethical issues in the workplace. Since I was unaware of what kinesiologists' responses would be, a semi-structured interview allowed some leeway for probing in different directions, under the assumption that different kinesiologists had different perceptions with respect to ethics and professionalism. The responses of kinesiologists were also compared with a document analysis of the CKO's standards, guidelines and code of ethics. Such an analysis based on scholarly sources assessed the soundness of the CKO's regulatory documents from an academic point of view.

Research Ethics

It is imperative that qualitative researchers be virtuous people and conduct ethically sound research if their studies are to be plausible and useful (Nyika, 2009). Liamputtong (2009) states, “Ethical issues have become an essential aspect of research” (p. 32). As someone who was doing research in the area of healthcare ethics, I was aware of some important concepts like confidentiality and anonymity that must guide a researcher’s practice. More specifically, my study included mostly face-to-face interviews where kinesiologists shared their knowledge and opinions of ethics and professionalism. As a researcher, I needed to be aware of the fact that having kinesiologists talk about ethics could have been somewhat emotional for them. For the purpose of this investigation regarding ethics and professionalism, I thought it would be important to include any information regarding sensitive issues. Fortunately, the interviewed participants in this study spoke freely and were open to discussing all topics about ethics and professionalism. For example, when asked to discuss any ethical situations that they may have faced in the workplace, many of the participants began by sharing their most sensitive situation without hesitation.

Nonetheless, I was not sure this would be the case when preparing to conduct the interviews and therefore I was prepared to address any potentially sensitive issues with caution. This was done by initially stating within the informed consent form that there was a chance that personal questions within the interview would have the potential to elicit emotional and psychological uneasiness (Appendix D). Participants were also informed they could refrain from answering any questions and were free to terminate their participation in the study at any point. When approaching potentially sensitive

topics, I would first ask if it was fine to talk about such a topic. When probing already talked about sensitive topics, I would ask if we could continue talking more about this topic. This approach let participants know that they did not have to talk about these subjects. This was important to me because it reflected my own moral values, as well as my duty as a researcher is to ensure the participant's well-being first.

All 11 participants held university degrees and were licensed to practice as kinesiologists in Ontario. They also spoke fluent English which meant there were no issues with understanding the informed consent form and their right to withdraw from the study. Each participant was given a number (1-11) and no specific names, dates, or organizations related to the participants were revealed.

Trustworthiness/Quality

In order to enhance trustworthiness of the data within my study I incorporated member checking. Member checking is an important technique for ensuring the credibility of a study (Lincoln & Guba, 1985). After conducting the interview and transcribing the data, I emailed a copy of the transcript to the participants for them to review and to provide feedback on its accuracy. They also provided comments on anything that I misread or misinterpreted. This allowed me to ensure that the data I collected and summarized accurately depicted the thoughts and perceptions of the kinesiologists. Although member checking can lead to inaccurate revisions by participants, it is a reasonable way to preserve the trustworthiness of the data.

At the beginning of each interview, I briefly shared my background in kinesiology and my interest in the study. This gave the participants a better idea of my academic credentials and why I was conducting the investigation. During this brief description, I

mentioned that I was a recent graduate of a university kinesiology program. This generated a common ground between the participants and me with the intention of creating a more comfortable setting for them. I anticipated that by knowing a little about me and raising their level of comfort, the participants would share more personal information than they would have otherwise shared.

Reflexivity

Within the interpretive paradigm, a good researcher is reflexive (Tracy, 2012). Liamputtong (2009) states, “as the researchers themselves are an integral part of their studies, it is impossible for them to be objectively distant from their research” (p. 25). Reflexive researchers are aware of their biases and prejudices when engaged in the research process and the impact they might have on it. Being reflexive involves being critical of one’s own values and opinions when conducting research (Tracy, 2010). An important part of reflexivity as a researcher is acknowledging one’s own personal history in relation to a specific topic and how it might influence the investigation (Liamputtong, 2009).

It is important that participants be reflexive as well because their responses to questions are interpretations of their reality. In my first interview question, I asked the participants about their history and familiarity with ethics within kinesiology and this revealed any biases they may have had. For example, perhaps they had taken a course on ethics and had formulated opinions on how to behave ethically with patients, contrary to CKO standards and guidelines.

What generated my interest in kinesiology and ethics began as an undergraduate student. My interests have always been in the area of kinesiology and that was the

undergraduate degree I pursued and completed successfully. My interest in ethics did not emerge until I was in my fourth year. I became fascinated with the concept of subjectivity. The idea that there are mostly contentious and disputable answers in ethics also impressed me. When I began to develop an interest in ethics it was at the same time I was learning about the development of the CKO. This was what led to my interest in ethics with respect to practicing kinesiologists. As a recent graduate from kinesiology, I understood the type of academic training that kinesiologists received before entering the workforce. If one received ethical education in university, as I did, it was sufficient in providing knowledge about ethical theories and ethical decision making models, but I believe that the workplace should also inform context-based ethical training. This was what motivated me to explore what practicing kinesiologists thought about ethics and professionalism.

Before proceeding, I would like to state two assumptions I made in conducting this study. First, I believe that since kinesiology is now regulated in Ontario many kinesiologists will be hesitant or reluctant to use and refer to the CKO's practice standards, guidelines and code of ethics. This is because they may see these regulations as disciplinary rather than as a tool for supporting their professional and ethical development. I hope that kinesiologists begin to see these regulatory documents as tools for guiding professional conduct and not as professional misconduct rules, which the CKO clearly differentiates on their website. Second, I contend that clinical based training at university is important for the ethical development of kinesiologists. It can be argued that through hands-on experience kinesiologists may actually develop bad habits when it comes to thinking and acting in an ethical and professional manner. However, I think that

the knowledge gained from hands-on experience and seeing ethics in action, whether good or bad, still establishes an important area for ethical and professional development.

Regarding the results of the study, I anticipated that the findings and conclusions of this study would provide working kinesiologists, as well as the CKO, relevant information about the ethical training and knowledge kinesiologists possess; how well prepared kinesiologists are when dealing with ethical issues; and ways to improve ethics education and training for kinesiologists. I believe that through interviews with kinesiologists I gained insight into the sorts of changes they wish to see with respect to their experiences and development in ethics and what they know about the CKO's professional standards and code of ethics that guide their practice. I hope to share the results, insights and conclusions of my study with other kinesiologists, the CKO and the OKA.

Chapter Development

Following this chapter, the second chapter will explain the research design and methodology. The overall structure of the study will be described, as well as the interpretive paradigm, main theoretical perspectives, the participants within the study, and how the data was collected and analyzed.

Chapter three will consist of the review of literature and the procedure for conducting the qualitative document analysis (QDA). The review of literature will discuss the history of kinesiology and ethics, common ethical issues within the healthcare system today, and how kinesiology became a regulated health profession in Ontario. This chapter will include a QDA of the CKO's practice standards and guidelines, as well as a QDA of the CKO's code of ethics. These analyses contain positive and negative

criticisms regarding the regulatory documents that the CKO has in place to govern the ethical and professional behavior of kinesiologists.

The fourth chapter will contain an analysis of the findings where I identify and explain the emergent themes based on the interview data that was collected. Support for these themes will be revealed from verbatim participant quotes and statements.

Finally, chapter five will discuss the findings, their significance and how they relate to my research questions. I discuss major findings and compare them with my QDA of the CKO's standards, guidelines and code of ethics. This chapter also includes suggestions for future research, limitations to my study and a number of conclusions.

Chapter Two

Research Design and Methodology

Paradigm

The paradigm of this study was an interpretive one. It is also known as the constructivist or constructionist paradigm and is an aspect of qualitative research (Tracy, 2012). The interpretive paradigm primarily understands the world and reality from the lived experiences of human beings. Therefore, reality is not something that is easily explained or measured because it is created through and given meaning by human interaction with the world and with others (Tracy, 2012). This approach was appropriate because the goal of this study was to explore the perceptions of practicing kinesiologists regarding the code of ethics and the ethical and professional guidelines set by the College of Kinesiologists of Ontario (CKO). I also wanted to learn about their ethical knowledge and training and how they dealt with ethical situations. The interpretive paradigm was well suited to this investigation because it helped me arrive at answers to the above listed research questions by asking kinesiologists what they knew and how they constructed their reality in real life circumstances.

One of the major assumptions of the interpretive paradigm is that there is no single reality and that multiple realities exist (Lather, 2006). I found that the kinesiologists I interviewed had many different and similar views with regard to the study's research questions. Having a difference of opinion in terms of what was important and what was not does not necessarily mean that all opinions were equal or that one view was absolutely right or wrong. A multiplicity of perceptions analyzed together disclosed some common, shared views of ethics and professionalism and revealed a

diversity of viewpoints in these areas. To date, as far as I know, no study such as the one conducted here has been carried out.

An interpretive framework was utilized in this investigation because it was assumed that kinesiologists would likely have different levels of experience, knowledge and training in ethics and professionalism. This turned out to be the case as there were varying levels of experience, knowledge and training, but interview responses also revealed a number of common features that kinesiologists shared when faced with ethical situations. Using an interpretive paradigm, therefore, allowed me to access the particular reality of each interview participant, discovering some common and differing perceptions kinesiologists possess.

Theoretical Perspectives

Working within the interpretive or constructivist paradigm, a specific theoretical perspective or methodology is selected to declare the set of assumptions and procedures a researcher operates from when conducting a qualitative study (Crotty, 1998). I considered a number of interpretive theoretical perspectives like phenomenology, grounded theory, and case study analysis, one of which might serve as a foundation for my research design and methodology. Phenomenology, which was derived from work of Edmund Husserl, is defined as a science of phenomena (Husserl, 2012). Husserl viewed phenomenology as a means of understanding our apprehension of the essence of phenomena via conscious and self-conscious experiences (Husserl, 2012). Phenomenology was further developed by Husserl's student Alfred Schutz. It was Schutz's goal to explain how the world was created and experienced by individuals (Schwandt, 2007).

In grounded theory, the main purpose is to allow the theory to emerge from the data as it is being collected (Glaser & Strauss, 1967). The authors stated, “Generating a theory from data means that most hypotheses and concepts not only come from the data, but are systematically worked out in relation to the data during the course of the research” (p. 6). An important method of analysis in grounded theory is comparative analysis. Glaser and Strauss (1967) believed that what they call “slices of data”, which are varying responses and thoughts of participants should be compared against one another to produce an array of results. In this way grounded theory may help researchers develop a theoretical framework for future research or help to explain a practice (Liamputtong, 2009).

Another interpretive theoretical perspective is the case study analysis. Investigation of a specific case involves multiple perspectives, factors and types of inquiry that are analyzed together to understand fully the context and meaning of the case (Stake, 2008). For example, the response of a hospital’s emergency ward and personnel to a shooting victim may be studied as a particular case on many different levels. As Stake (2008) asserts, “case studies are of value in refining theory and suggesting complexities for further investigation, as well as helping to establish the limits of generalizability” (p. 104).

In considering the preceding theoretical perspectives I did not want to examine the experience of a single phenomenon kinesiologists may have shared; or develop a theory based on the ethics experiences of several practicing kinesiologists; or analyze a case involving an ethical crisis and how kinesiologists and others responded. Instead, I was impressed with and followed the lead of Thorne, Kirkham & O’Flynn-Magee (2004)

who claimed that the above theoretical perspectives are not always conducive to a particular investigation. As a result, the methodology or theoretical perspective that I chose to guide my data collection and analysis was interpretive description (ID). As will be explained below, ID is not a generic expression that encompasses broad characteristics of qualitative research and the interpretive paradigm.

To elaborate, ID was first developed in 1997 by a team of qualitative researchers. A member of this team explained, “This method departed from the specific methods dominating qualitative nursing research at the time, and reflected the evolution of qualitative methodology within the disciplinary domain of nursing” (Thorne et al., 2004, p. 1). ID was designed as an alternative methodology, allowing nurses to develop more specific research projects and not be constrained by the philosophical and sociological assumptions of methodologies like phenomenology and grounded theory. ID focuses on researchers interpreting subjective information that has relevance in practical/clinical environments (Thorne et al., 2004). This applied to my study because I examined the perceptions and lived experiences of those who now practice kinesiology as CKO members.

ID was used in the data collection phase of this investigation. Interpretive skills were needed to design interview questions based on the main research questions of the study. Furthermore, I conducted semi-structured interviews where probing questions went beyond the interview guide questions. Probing questions were generated by interpreting responses and taking interview discussions in several relevant directions. For example, if I felt a participant did not describe or explain a point fully, I would ask for further elaboration or clarification. Knowing the appropriate place and time for extended

discussion required that I interpret what was being said and decide if more information was needed. Another ID feature occurred before each interview when I described to each participant a hypothetical ethical situation in the workplace (Appendix A). This scenario was presented to ensure all participants understood what was meant by an ethical situation and if necessary I could clarify this meaning. Finally, during the interviews I tried to remove as much of my influence from the participants answers as possible. This meant avoiding leading questions that would influence the participants to answer in a certain way.

ID was then used in the analysis of the interview data as a means of disclosing patterns and generating themes that would be of practical use. Hunt (2009) elaborated, “ID researchers examine a clinical phenomenon with the goal of identifying themes and patterns among subjective perspectives, while also accounting for variations between individuals” (p. 1285). ID assumes that multiple realities exist and that information and knowledge are dependent on the context of particular situations and the people who act and interact within them.

During the analysis phase of the study, I grouped participants’ answers and responses together to generate any common themes and patterns from the participants’ responses and interpretations. I wanted to interpret and abstract the information in a way that would be supported by relevant participant responses and make sure these themes provided coherent and plausible answers to the research questions posed in this study.

Finally, through the use of ID, I described and analyzed the interview data collected in this study in a comprehensive manner. That is, rich descriptions were collected and reported that conveyed the interpretations of participants and how they

constructed their realities. Moreover, an analysis of participant data was implemented utilizing my interpretive research skills to reveal significant emergent themes and patterns.

Participants

Eleven active kinesiologists were interviewed in my study. The term “active” referred to their professional status as currently practicing professionals, as opposed to inactive kinesiologists who were CKO registered but were not providing care or services to the public. Participants also had to have at least one year’s experience in the field. This was to ensure they had some experience with ethical issues in the workplace and perhaps consulted the ethical guidelines and practice standards of the CKO.

Kinesiologists were employed in various work settings. These environments included hospitals, physiotherapy and chiropractor clinics, assessment clinics, as well as private companies or organizations. Due to the varying workplaces and skills of the interviewed kinesiologists, data saturation was not fully reached as new thoughts and perceptions emerged in each interview. However, due to time and travel restraints I encountered as the researcher, data collection was completed after conducting 11 interviews. I also had difficulty recruiting participants for my study. For this reason I had to go outside of my originally set boundary of Niagara to Mississauga. Ten of my 11 participants were from the Niagara to Mississauga region and one was from the city of Belleville, which is roughly two hours east of Toronto.

Recruitment and Data Collection Procedure

The timeframe taken to collect the data was from November 2013 to April 2014. When recruiting participants, I used the CKO’s online registry which lists contact

information for all registered kinesiologists in Ontario. Potential participants were contacted via telephone (see Appendix E) where I briefly described the study. Invitation letters were then sent via email to the interested practicing kinesiologists (see Appendices F and C). I followed-up with a phone call to arrange an interview place, date and time. When we met for the interview I again described the study to the participant and outlined details of the potential benefits and harms. I wanted the participants to be clear about the purpose and nature of the research because they may have had different ideas of what was being asked of them. Once the participant understood what the study entailed, she or he signed the consent form and I proceeded with the interview (see Appendix D).

Interviews took place at the most convenient place for participants. If they had an office or somewhere private and quiet at their work then that was where the interview took place. If somewhere quiet and private was not available then the next best choice was to conduct the interview at my university. Fortunately each participant had a desired place that he or she wished to meet for the interview. The participants then filled out a short questionnaire regarding background and demographic information (age, education, etc.) at the start of the interview (see Appendix B). Once that was completed, the interview started. The semi-structured interviews were conducted face-to-face and consisted of 10 open-ended questions. The open-ended questions were derived from readings on kinesiology and ethics as well as literature on ethics of other regulated health professions. Of the 11 interviews conducted, nine were conducted face-to-face and two were conducted via telephone. The average length of the interviews was roughly 40 minutes long.

A digital recorder was used to record the interview with each kinesiologist. Also, notes were taken immediately after the interview to record my own personal reflections and non-verbal cues I noticed among the participants like facial expressions, body language, moments of silence, etc. Once the data collection had taken place, a verbatim transcript was produced. The transcript was sent to each kinesiologist for member checking.

Analysis

As described earlier, interpretation, as part of ID, is an element of the data analysed, where patterns and themes arise from the data. The reason for using ID was so that I could code participant responses, finding commonalities in the data, and identifying overarching themes to make sense of the data. As outlined in ID, searching for and developing patterns and themes found in the data is a popular method of abstraction. The following explains how I conducted my analysis.

First, I tried to make sense of each individual interview transcript by reading it thoroughly. Second, I examined all the transcripts collectively to try and understand what the participants were saying as a group in search of repeated patterns of meaning. ID was part of this abstraction process by employing my interpretive research skills. Liamputtong (2009) states that “in carrying out coding, the researchers name chunks of data with ‘a label that simultaneously categorizes, summarizes, and accounts for each piece of data’” (p. 278). This was my first time conducting qualitative research and I was relatively unfamiliar with such data analysis. Therefore I used a coding strategy by Braun and Clark (2006), which provided a step by step framework for coding data:

1. Familiarize yourself with your data by transcribing it yourself and then reading and re-reading it, jotting down your initial thoughts.
2. Then start to formulate general codes. This is done by identifying general statements or words that express some meaning towards the purpose of the research.
3. These statements and words will then be synthesized into themes.
4. Revise the themes you have developed to ensure that they are related to the codes you have produced.
5. Continue to analyze and refine your themes so that you may develop clear names and definitions of the themes.

Using this method proposed by Braun and Clark (2006) ensured that all the interview transcripts were analyzed using the same step-by-step procedure.

The two instruments used in the collection of data were the questionnaire and the interview guide. The questionnaire was designed to gather an understanding of the participant's level of training and work setting. A simple demographic inquiry, the questionnaire (Appendix B) asked six questions regarding age, sex, years of experience, number of months as a regulated kinesiologist, work setting and highest level of education. The questionnaire also served as a method for generating conversation between the researcher and participant as we would discuss where they went to school and their place of work.

The interview guide (Appendix A) was developed carefully based on current literature from similar healthcare professions such as physiotherapy, nursing, medicine and occupational therapy. After critiquing and refining the interview guide, 10 open

ended questions developed. After the first few interviews, an eleventh question was added because participants showed an interest in talking about how regulation might influence the university curriculum in terms of ethics and professional training. Throughout each interview, probing questions were developed and refined progressively, and changed slightly from interview to interview depending on the participant's thoughts and interests. The first half of the interview would focus on discussing more general topics like the regulations of the College and the participants' ethical training and background. The second half of the interview focused more on ethical conflicts and the CKO's practice standards, guidelines, and code of ethics. Ordering the questions this way allowed the participants to get settled in before having to discuss potentially stressful memories of ethical issues.

Another aspect of my analysis included a critical examination of the CKO's formally stated practice standards, guidelines and code of ethics through qualitative document analysis (QDA). Bowen (2009) states, "Document analysis is a systematic procedure for reviewing or evaluating documents" (p. 27). He described document analysis as finding, selecting, appraising (making sense of), and synthesising the information contained within documents.

In applying this approach, I first read, and then re-read the documents to obtain a broad understanding of the material. I was mostly interested in the clarity of the documents, whether or not their organization and progression made sense, were proper terms clearly defined and could they be interpreted with relative ease. I then analyzed the documents to uncover their assumptions and the spirit they were trying to convey to assist practitioners. This layer of analysis helped me determine if these documents do what they

were designed to do. I acknowledge that my interpretation at this stage may differ from others. The third step of my analysis was to analyze the documents and synthesize the information (Bowen, 2009). To accomplish this task I used part of the procedure proposed by Braun and Clark (2006). This synthesis generated thematic categories. Along with this, sources in the literature demonstrate how QDA can be employed to critique codes of ethics, discuss such analyses from other perspectives, and those that review and comment on standards and guidelines within other health professions (Wach, Ward & Jacimovic, 2013).

One limitation to document analysis that I needed to be aware of was biased selectivity (Bowen, 2009). Since I selected the documents I wished to analyze as well as the literature base for my knowledge regarding issues with practice standards, guidelines and codes of ethics, I cannot state that my QDA was completely free of bias.

This chapter described the interpretive paradigm that was set as the foundation for the research design of this study. It then explained briefly a few interpretive theoretical frameworks and explained that interpretive description (ID) would provide the methodological basis for collecting and analyzing interview data. The chapter discussed how interview participants were recruited, how the interview guide was developed, and how the data was collected. A short description of the data analysis phase of the study was also presented. The chapter concluded by describing briefly qualitative document analysis (QDA) which was utilized to analyze the regulatory documents of the CKO. The following chapter will contextualize this study, to a limited degree, by discussing the development of healthcare ethics generally, the history of kinesiology in Canada, ethical

issues in kinesiology, and the CKO's practice standards and guidelines as well as its code of ethics. The QDA was applied to the preceding two topics.

Chapter Three

Review of Literature

Introduction

The purpose of this review of literature is to present a short account of the development of healthcare ethics, a historical sketch of kinesiology in Canada, ethical issues in kinesiology, and a critique of the College of Kinesiologists of Ontario's (CKO) practice standards and guidelines, and its code of ethics.

The CKO, along with every other healthcare profession, provides practice standards, guidelines and a code of ethics to their members. The practice standards are designed to inform the College's members of their duty to maintain compliance with the professional misconduct regulation. The professional misconduct regulation is contained within the Kinesiology Act of 2007 and stipulates what would be considered professional misconduct as a registered kinesiologist. The presumption is that by knowing and avoiding misconduct, kinesiologists would be expected to behave ethically and professionally. The practice standards consist of 13 sections (see Appendix I for an example of one of the standards). Moreover, the CKO currently has eight practice guidelines. The practice guidelines are designed to help kinesiologists understand better the practice standards. They do so by elaborating and explaining the standards and provide more detail on specific types of professional misconduct (See Appendix J for an example of a practice guideline).

The Development of Healthcare Ethics

The concept of ethics in healthcare was first articulated in Western history during ancient times. The famous ancient Greek physician and philosopher Hippocrates, who

lived in the fifth century before the Common Era (BCE), is credited with establishing the first principles of healthcare ethics. As a physician, he discovered remedies for numerous ailments that focused on the environment as the source of disease and not mysterious inflictions imposed by the gods. He also believed that physicians should be honourable in their practice (Breen et al., 2008). It is believed that Hippocrates either wrote or inspired what we now know as the Hippocratic Oath. This historical oath taken by physicians has a longstanding tradition with the intended purpose of ensuring that they practice medicine honorably and maintain ethical standards. A modern version of the Hippocratic Oath is available in Appendix H (Lasagna, 1964).

Ethical values and principles contained within the Hippocratic Oath are respect, beneficence, the principle of care, justice, communication and collaboration, honesty and integrity. These ideals conveyed through the Hippocratic Oath are still used today, and three of them are mentioned within the CKO's code of ethics (Appendix K).

From ancient times to the present, a concern for ethics in healthcare has been expressed in many forms. For example, the preservation or saving a life in Judaism is a cardinal rule that supersedes most other religious rules (Loewy & Loewy, 2004).

“Medical deontology” was developed during medieval times when Europe was devastated by the plague. Many physicians then believed they had a duty to help their patients despite the risk of getting sick themselves. Deontology in this case refers to the physicians believing they had a moral duty to treat their patients and to provide care for them regardless of the consequences. At the turn of the 17th century, more formal works of medical ethics began to appear. For example, Rodericus a Castro published a book titled, *The Responsible Physician, or the Duties of the Physician Towards the Public*

(cited in Loewy & Loewy, 2004). In the 18th century, ethical thinking began to emphasize principles like autonomy (respect for individuals to make their own moral decisions) and human rights (equal rights despite socio-economic differences) and eventually, these ideas began to influence ethics in health and medicine.

In the 20th century, during the Nazi era, medical human experimentation was conducted by physicians and researchers that grossly violated ethical principles and human rights. The unethical use of human subjects in Nazi experiments led to the creation of the Nuremberg Code. The Nuremberg Code was developed as a guide to conduct ethical experimentation with human beings. Nazi experiments along with other unethical studies like the Tuskegee experiment, in which African-Americans were knowingly inflicted with syphilis, are in part the reason that Institutional Review Boards (IRBs) were developed (Loewy & Loewy, 2004). IRBs were designed to review any research, particularly in health and medicine, that involved human beings to ensure that the research being conducted was ethically sound and protect participants from harm.

Codes of ethics, however, are not designed only for researchers. For example, businesses, corporations, governments and healthcare professions all have codes of ethics that guide ethical conduct in the workplace. With regard to healthcare, codes of ethics are important because healthcare professionals work with populations who are vulnerable and require protection. A code of ethics provides health professionals with guidelines on how to conduct their practices ethically, and gives them a framework for dealing with ethical issues (Canadian Nurses Association, 2008). It also provides the public with information regarding the values that healthcare professionals should bring to every interaction with patients. A code of ethics serves as a tool for self-evaluation, allows

healthcare workers (e.g., nurses) to assess how they should respond to future issues and how they have responded to previous issues (Canadian Nurses Association, 2008).

As a specific example, the Canadian Medical Association first developed its code of ethics in 1868. Since then, it has been updated 19 times, most recently in 2004. When reading the 1868 document and the 2004 version, it is clear that many of the original principles have remained unchanged in what has been almost 150 years. The notion of being ethically and morally good has existed for some time. Interestingly, many of the principles and values of the ancient physician-philosophers are still shared by healthcare professionals today. This may show that the human race has a relatively good grasp on what is right and wrong, at least on a theoretical level.

A History of Kinesiology in Canada

In addition to a short account of healthcare ethics in the preceding section, it would be useful to discuss briefly the origins of kinesiology in Canada because kinesiology as a regulated healthcare profession is a recent development. Kinesiology was first established as a university academic program in the late 1960s. The first two schools to introduce kinesiology were Simon Fraser University and the University of Waterloo (Elliot, 2007). The kinesiology program at Waterloo was developed by Professor Norm Ashton who originally called the program the “nonprofessional study of human physical movement” (Elliot, 2007, p. 160). The first MSc and PhD programs were established in 1972 and 1976 respectively. Meanwhile, at Simon Fraser University, kinesiology was introduced into the Faculty of Education. Over the next 20 years or so, kinesiology began to grow substantially, mostly due to the large number of physical

education teacher graduates and the increase in demand within society for jobs in the rehabilitative and ergonomic sectors (Elliot, 2007).

Starting with their first national meeting in 1971, an organization known as the Canadian Council of University Physical Education and Kinesiology Administrators (CCUPEKA) was instrumental in refining and improving the curriculum for kinesiology and physical education programs. In 2000, CCUPEKA established an accreditation process for Canadian university kinesiology and physical education programs to evaluate and set minimum standards for education and training in these fields.

Two other important organizations emerged to advance the development of kinesiology. In 1981, the Ontario Kinesiology Association (OKA) operated as a non-profit organization to promote and enhance the profession of kinesiology (OKA, 2013). Over the years the OKA has registered a large member base and now has over 2,000 members. As stated on its website, “The OKA currently engages in advocacy work on behalf of its members. We also serve to promote the profession of kinesiology to the general public, third party payers, and other healthcare providers” (OKA, 2013).

Founded in 1995, the second organization, known as the Canadian Kinesiology Alliance-Alliance Canadienne de Kinésiologie (CKA/ACK), advocates for the profession of kinesiology on a national scale. In 2006 the CKA developed a scope of practice for kinesiologists in the following sense: “The practice of Kinesiology is the assessment of movement, performance, and function; and the rehabilitation, prevention, and management of disorders to maintain, rehabilitate, and enhance movement, performance, and function in the areas of sport, recreation, work, exercise, and activities of daily living” (as cited in Elliot, 2007, p. 160). The CKA had also developed a certification

process requiring all those who wished to be certified to have earned a four-year degree from an accredited kinesiology or human kinetics department. In addition to a degree, applicants must verify they have successfully completed specific courses within the degree, like anatomy, biomechanics, human physiology and motor control and learning. Circumstances are now dramatically different in Ontario.

Due to the growing popularity of kinesiology along with the advocacy efforts of groups like the CKA/ACK and the OKA, several years ago the government of Ontario began to consider making kinesiology a regulated health profession in Ontario. In 2005, OKA prepared and submitted the document to the Health Professions Regulatory Advisory Council (HPRAC) asking that kinesiology become a regulated health profession under the 1991 Regulatory Health Professions Act (RHPA). A year later HPRAC recommended to the Minister of Health and Long-term Care that kinesiology be regulated and this led to the Kinesiology Act being passed in 2007 by the Ontario legislature. Under the Kinesiology Act, 2007, the scope of practice of kinesiology in Ontario is defined as “The assessment of human movement and performance and its rehabilitation and management to maintain, rehabilitate or enhance movement and performance”. A Transitional Council was then established to set the registration of kinesiologists, educational qualifications, practice standards, complaints and discipline, and College governance. The work of the Transitional Council resulted in the official proclamation of the College of Kinesiologists of Ontario (CKO) which occurred on the first of April 2013.

Now that kinesiology is regulated in Ontario, the CKO ensures its members are competent and have a high level of knowledge and experience. Moreover, the title

“kinesiologist” is restricted in use to only members of the College. This restriction is limited to specific designations like R. Kin., Registered Kinesiologist or Kinesiologist. Under this protected title, kinesiologists have attained a new professional status that is more widely respected in a variety of healthcare settings such as the insurance industry, hospitals, rehabilitation and therapy centres and private clubs. Ontario kinesiologists no longer require another regulated healthcare professional to sign off on their work, and are able to perform delegated procedures that they are competently trained in (College of Kinesiologists of Ontario, 2013).

There is still much more room for kinesiology to grow as a profession and as an academic discipline. It is uncertain how exactly the professionalization of the discipline will affect kinesiology curricula in universities. One theory is that it may take a similar route as psychology, having one side of it focus on the clinical aspects of kinesiology while the other side focus on academics and research (Elliot, 2007).

Ethical Issues in Kinesiology

There is very little literature regarding kinesiology ethics and professionalism. What literature there is stems from other regulated health professions like nursing, physiotherapy, and occupational therapy. There is evidence to suggest that practitioners in these longstanding healthcare settings continue to struggle with ethics in professionalism. For example, nurses frequently experience conflict between what they think is morally right and what their governing body believes (Austin, 2012). Not only is there a struggle between practitioners and their governing bodies, but also between practitioners themselves. For instance, different healthcare professionals working under the same organization often have conflicting ideas and decisions about what is best for

patients because sometimes inequities exist in the distribution of resources (Gaudine, LeFort, Lamb, & Thorne, 2011). This may mean that some healthcare departments receive less money in areas like staffing and equipment funding and as consequence patient care is negatively affected.

Ethical issues are experienced by physiotherapists daily, if not more than once a day. A study conducted by Praestegaard and Gard (2013) investigated the type of ethical issues physiotherapists face. They defined an ethical issue as a specific situation where alternative decisions are weighed against an ethical problem. One ethical issue physiotherapists raised had to do with one's level of experience. Physiotherapists mentioned that they are often unsure what to do when treating a patient and must then refer the patient to a colleague. But when this happens their colleague is often too busy and therefore, physiotherapists cannot adequately treat their patient. This makes them feel frustrated because they feel they may not be doing everything they can for that patient. Another issue that several physiotherapists talked about was illegally adjusting the rules of government subsidies so that they could provide the best possible care for their patient. For example, if someone should be getting treatment for five weeks, but after the five weeks was still in pain, the physiotherapist may adjust dates and bills to allow the patient more time in the clinic. One physiotherapist mentioned that even though he or she knows it is illegal, they do it because they feel it is in the patient's interest (Praestegaard & Gard, 2013).

Problems are faced every day by healthcare practitioners in situations where they must make a decision between two alternatives. Problems also arise when healthcare practitioners do not have the knowledge or guidance to make a good decision, or even

know when they are making a bad one. Nurses from a study in the United Kingdom felt as though codes of ethics seemed more as a guideline for discipline as opposed to a tool for helping them resolve situations (Pattison, 2001). This brings up the notion that the training and or guidance given to healthcare practitioners is often lacking in its ability to allow them to properly deal with ethical issues in the workplace. For example, the CKO asserts, “Regulation of the profession by the Ontario Government ensures that kinesiologists meet and adhere to a common set of professional standards, a Code of Ethics, and participate in ongoing professional development” (College of Kinesiologists of Ontario, About the College, 2013). This statement claims that kinesiologists do know what they are doing and for the most part can do it well, but this may not conform to what takes place in practice, as kinesiologists have not experienced working as regulated health professionals. The latter situation appears in the literature in other healthcare professions where in some cases minimum standards are not being met. For example, research has shown that some nurses feel as though they lack ethical knowledge when faced with an actual ethical situation (Doane et al., 2009).

Another way in which ethical issues arise in kinesiology is in the education system. Numerous aspects of training and education will have to change in order to better prepare entry-level professional kinesiologists. Unlike other regulated health professions, most kinesiologists do not benefit from a professional training program or an internship with defined learning objectives. In other professions like medicine, ethics and professionalism training is standard practice for all medical students along with some form of internship or practicum (Stephenson, Higgs, & Sugarman, 2001). In the university I attended, for example, the only requirement for students in the kinesiology

program is that they take one half-credit course on ethics and professionalism. Although internships and professional training programs do not teach ethics and professionalism directly, by working in a healthcare environment, one may gain first-hand knowledge about ethical situations, how to deal with them and how to avoid them. This suggests that we must try and provide clinical experience for kinesiologists in their undergraduate degree programs. This will allow kinesiologists to benefit from hands-on experience of providing care and resolving ethical issues like how to write clear and detailed clinical notes and how to correctly store health records. While there is the risk of learning poor ethical behavior and observing poor moral judgments as student interns in clinical settings, with careful oversight and supervision these experiences can be minimized and the risk is not sufficient to forego clinical training completely.

Two very important questions should be asked in healthcare ethics education: what constitutes ethical practice for healthcare professionals and what ethical challenges do practitioners face daily (Delany, Spriggs, Fry, & Gillam, 2010)? Fortunately for other health professions like nursing and medicine, there is an extensive literature base that can answer both of these questions with substantial depth. In kinesiology, there are few sources in the literature that answer the first question and even fewer that can answer the second. Fortunately, documents like the “Kinesiology Core Competency Profile” produced by the CKO provide information for kinesiologists that are gathered from experienced kinesiologists and academics. Included in this material is specific information regarding ethics and professionalism in kinesiology.

Questions regarding how ethics and professional training in kinesiology should be taught arise when reading the kinesiology core competency profile. A section within the

profile is labelled “communication and collaboration.” Within the section is a statement saying that kinesiologists must be able to work together with other healthcare professionals as a member of an interprofessional team. This may lead to the question, should ethics and professional education incorporate single-professional or interprofessional learning? Catherine and Braun (2011) state there are both benefits and challenges to single-professional and interprofessional education. Much of the ethical training in kinesiology undergraduate programs uses a single-professional approach, where individual disciplinary ethical dilemmas are examined. Less focus is given to how health professionals interact with one another when there are ethical problems, but this may be beneficial because there is much to gain from creating mutual respect between healthcare professionals (Catherine & Braun, 2011). With the CKO placing emphasis on kinesiologists working within a team, it may be advantageous to address the issue of interprofessional education, and incorporate some form of interprofessional training in ethics education.

Practice Standards and Guidelines

From reading and re-reading the CKO’s practice standards and guidelines it is my understanding that the main and obvious purpose of these documents is to protect the public. They provide adequate information not only for the members of the CKO regarding their responsibilities but also information for the public, so the public is aware of the level of professionalism they are to expect from kinesiologists. Ensuring that members of the College are aware of each of the standards and what each standard entails is important for keeping the public safe.

The second purpose for developing these standards is to educate the members of the College. Many of the standards provide new information that kinesiologists may not have known before becoming registered and may still not know. With each section of the standards there are several small details that, if overlooked in practice, could be construed as professional misconduct. For example, in advertising a kinesiologist cannot post a testimonial from a client. This is something that a kinesiologist may not be aware of when putting an advertisement in a newspaper to promote his or her practice. Some of the standards may be viewed as restrictive tools, used to discipline members rather than help them resolve their ethical issues. However strict they may seem, the ultimate goal is to ensure that members are practicing safely, so that they do not do anything that could cause them or the public harm. Is this the best method for ensuring members are aware of the practice standards and guidelines, and that they follow them, or would it be more beneficial to develop more supportive documents for promoting knowledge, understanding and growth? This will be discussed in the qualitative document analysis (QDA) below.

The College's goal, however, is not only to educate their current members, but their future members as well. Another purpose for developing the standards is to allow the profession to grow through practical training experiences for students. Providing clinical education to students is emphasized in one section of the standards. The reason for this section is to benefit future kinesiologists to ensure they are properly trained and experienced when it comes time to register with the CKO. Before conducting a document analysis of the CKO's practice standards and guidelines, I will comment briefly on the CKO's code of ethics.

Code of Ethics

Contained within the CKO's standards is the College's code of ethics. It becomes clear from a careful reading of the code that its main purpose is to protect the public. As the Transitional Council (2012) stated, "The Code of Ethics reflects kinesiologists' commitment to use their knowledge and expertise to promote high quality, competent and ethical care for patients and clients and thereby instill in the public, confidence in the profession" (p. 1). As a new profession it is important that kinesiologists conduct themselves professionally and provide safe and competent care for the public in order to promote the integrity of the profession. The code of ethics also makes reference to kinesiologists developing their knowledge and experience in ethics. The stepwise decision-making model encourages kinesiologists to learn and grow from their ethical experiences.

However, this document does not provide any information or support encouraging kinesiologists to protect themselves. Emphasis is placed solely on protecting the public, with no mention as to how kinesiologists can protect themselves. The only reference the code of ethics makes regarding the safety of kinesiologists is the step by step decision-making model which may help kinesiologists feel more secure when making ethical decisions in the best interest of the patient. It is extremely important to protect the well-being and safety of the public, but it also may be significant to guide the professional interests of kinesiologists. There needs to be more information and concrete examples within the code of ethics to explain how kinesiologists may apply ethical values and principles in practical situations in consistent ways so the public is protected and the highest professional standards are maintained.

The following is a critical document analysis of the CKO's practice standards and guidelines. In the subsequent section, a similar analysis of its code of ethics will be presented, and each analysis will be organized into thematic areas.

Document Analysis of the CKO's Practice Standards and Guidelines

The standards and guidelines set forth on the CKO's website are a representation of an original document set forth by the government of Ontario pertaining to the legislation of the 2007 Kinesiology Act and the 1991 Regulatory Health Professions Act. It was the task of the College to draft this legislation into the standards and guidelines for the profession of kinesiology. The purpose of this qualitative document analysis is to assess and critique these standards and guidelines, and in the next section, to do the same with the CKO's code of ethics. As a result of this assessment and critique, a number of themes were identified and examined by the researcher. These themes were developed by conducting a literature search to obtain sources that investigated standards of professional practice, as well as codes of ethics to be addressed in the subsequent section.

Theme One – Misinterpretation of Key Terms

The standards and guidelines present several complex and ambiguous terms. Some of these terms are common to the health profession and are easily understood and some are not. More specifically, those words which relate to ethics may be misunderstood and can hold different meanings to diverse people. For example, Seedhouse and Gallagher (2002) state, "References to dignity are commonplace in aspirational codes and policy statements for health professionals" (p. 368). Thus, one finds the word dignity used throughout the CKO's standards and guidelines yet its precise meaning may not be clear. Most people have a general comprehension of the term dignity but it can easily be

misunderstood and has ambiguous meaning in certain contexts. According to Seedhouse and Gallagher (2002), “Everyone agrees that human dignity is important and should be respected but nowhere – in any of this proliferation of codes and mission statements – is dignity defined” (p. 368).

Within the practice standard on discharging a client, reference to the word “abuse” is made. It is mentioned that grounds for discharge may be warranted if a client becomes abusive. Yet nowhere in the document does it define what is and is not abuse. The term abuse is defined within the professional boundaries standard, yet kinesiologists may not be aware of this when they look up the standard on discharging a client. This may cause confusion and stress for kinesiologists because they may think a client is being abusive but with no clear definition they may be worried a complaint to the College by a discharged patient will jeopardize their career. Other terms that can be misinterpreted, especially when definitions of such words are not explained with clarity are “controlled acts,” “autonomy” and “professional boundaries.”

Therefore, there needs to be clearer definitions of vague terms like dignity and abuse in the CKO’s standards and guidelines to minimize any misinterpretations and misapplications of these key terms.

Theme Two – Patient-Practitioner Relationship

This second theme questions whether or not the standards and guidelines of the College focused primarily on therapeutic settings, thus perhaps ignoring important factors in other workplace environments. The reason for identifying this theme is in part due to the fact kinesiologists can work in many different employment settings, whether in a rehabilitation center, in a disability management role or even with insurance companies.

Throughout the analysis process my first interpretation led me to think that the standards and guidelines were too narrowly focused on the therapeutic relationship. There is little reference to kinesiologists in management roles or those who work with insurance companies and other organizations like the Workplace Safety and Insurance Board (WSIB) that process injury and safety claims or return to work programs. Functioning in these roles suggests kinesiologists remain more objective and they need not develop direct relationships with clients. However, my overall conclusion is that the regulatory documents are more focused on the therapeutic relationship between patient and practitioner for good reasons as will be explained in the following.

The scope of practice outlined by the College is focused more towards working directly with patients, and the majority of kinesiologists currently practicing do in fact treat patients directly and develop such care relationships. Another reason for this is many of the employment agencies who hire kinesiologists for other than rehabilitative reasons have standards and guidelines of their own, pertaining to what their employees can and cannot do. For example, I believe the College's reason for addressing more exclusively kinesiologists who work directly with patients is because of the primary concern for protecting the welfare and safety of the public. Hands-on care with patients creates relationships where standards such as sexual abuse, professional boundaries, dual healthcare, consent, infection control and clinical education may require physically applying treatments which may have greater potential to directly involve patient risk and harm. Kinesiologists who do not focus on directly applying treatments and who are required to remain objective when dealing with patients or employees do not need to worry as much with regard to the standards listed above. For example, kinesiologists who

work in disability management positions and analyze injury reports do not directly treat employees who are injured on the job. Instead, they are given assessments from a third party regarding employee injury, required to develop return to work programs, and make adjustments to the employee's occupational setting to accommodate workplace injuries.

Since the main goal of the College's practice standards and guidelines is to protect the public's safety, health, and well-being, it seems appropriate that it focus on kinesiology workplace settings where direct interactions with patients may pose a greater risk. However, certain professional standards and guidelines should be provided for kinesiologists who have indirect contact with patients.

Theme Three – Practical Presentation

Currently, the standards and guidelines are organized in alphabetical order on the CKO website. Each standard and guideline is then followed by a relatively uniform list of headings which are addressed one after the other before mentioning details specific to that particular standard or guideline. Almost all documents start with definitions, then state objectives or intent, and next provide a description of the standard before specifying a topic or issue. For example, the conflict of interest document begins with a definition, then speaks to the intent of the document, followed by the document's objectives and a description of the standard before discussing issues and rules specific to conflict of interest. From a practical perspective these documents are presented well and in an organized manner. My only recommendation would be to include a table of contents, detailing each standard and guideline, as well as each heading within every document to more easily identify and locate a particular topic. This however may not be necessary because the overall size of the collective documents is relatively smaller than other

Colleges like nursing, thus making it easy to navigate through fewer documents in order to find the exact topic you would like to identify and read about.

Theme Four – Supportive or Authoritative

One may question whether or not the standards and guidelines of the College are framed as authoritative regulations that must be followed like the rule of law, and if such laws are violated they carry stiff disciplinary penalties. Or, perhaps they are constructed as supportive guides and teaching tools to deal with ethical issues and professional problems? For example, in general codes of ethics are meant to be supportive because their goal is to develop understanding among College members so they know their professional responsibilities as registered health practitioners (Hubert & Murphy, 2006). Following this view, practice standards and guidelines may also serve a better purpose if developed as supportive rather than authoritative regulations. Let me explain what I mean by the latter.

When reading through the CKO documents I noticed that the guidelines developed by the College serve primarily as supportive documents to develop a member's knowledge and understanding of a particular area. Standards without such guidelines were more authoritative and they mainly emphasized compliance. Perhaps this was so because the College must insist that for some standards there is a zero tolerance policy. For example, when creating advertisements, the College provides a guideline along with the standard to make sure that kinesiologists understand how to properly and safely produce an advertisement for their services. Standards like infection control need to be strict with regard to how to properly sanitize and clean one's workplace so patients, practitioners, staff and visitors, etc. are safe. A good mixture of authoritative and

supportive documents allows the members to understand, learn and grow in areas like advertising, consent, fees and billings, mandatory reporting, privacy and confidentiality of personal health information, scope of practice, controlled acts and delegation, the therapeutic client relationship, the prevention of sexual abuse, and the use of title and designations. Such documents also make sure members adhere very strictly to standards like clinical education, conflict of interest, discharging a client, dual healthcare, infection control, professional collaboration and record keeping. Still, I recommend all the standards should have explanatory guidelines to help members understand their importance and achieve greater compliance.

As a recent kinesiology graduate, I believe one of the most important things that was missing from my undergraduate program were clinical placements because there were no opportunities to observe and learn about ethics in action or as practiced in the workplace. Therefore, developing a guideline for clinical education, supervision, and delegation should be implemented to further promote the involvement of students with practicing kinesiologists. As it stands now the CKO promotes practical student experience in the clinical education standard, but College members are required to assume full responsibility and accountability of student clinical training and there are potential ethical issues that arise from this. For example, a student may not be familiar with professional boundaries and if subjected to sexual harassment or harm, may not understand or file a complaint as such. It is important to clearly identify the risks involved when implementing clinical field experiences, both for students and registered kinesiologists whose careers might be jeopardized if professional conduct is not compromised. More detail should be included to explain how accountability and

responsibility work when supervising students. Also, the standard should identify benefits not only for the members and students, but to the kinesiology community as a whole so clinical education is carried out with many stakeholders in mind.

Theme Five - Brevity

This theme considers the length of the documents and whether or not they are overly brief. When one compares the CKO's standards to other professions (e.g., nursing and physiotherapy) there are some similarities and differences that refer to the brevity of the documents. With regard to the College of Nurses of Ontario (CNO), for example, there is a difference in the number of guidelines as compared to standards. The CNO focuses more on guidelines, ensuring that a better understanding of and guidance from the regulatory documents is obtained whereas the CKO focuses less on guidance and more on simple adherence to standards. Also, even though there are a similar number of total standards and guidelines (21 for the CKO and 27 for the CNO), the depth of content within the nursing standards and guidelines is much deeper than that of kinesiology. For example, the standard on infection control for the CKO is four pages long whereas the standard for infection prevention and control for the CNO is 12 pages long. This could be viewed as a benefit to either profession. On the one hand, for an emerging profession like kinesiology where new ethical issues may arise a brief document may be more beneficial, whereas an long established profession like nursing where years of experience with ethical problems has existed may require a deeper description of each standard. Similarly if codes of ethics are too long, they can become too overwhelming to read (Huburt & Murphy, 2006).

When one compares the CKO's standards and guidelines to the College of Physiotherapists of Ontario (CPO) there are many similarities. Several headings are similar if not the same. The length of the documents are relatively similar. It appears that when the CKO standards and guidelines were developed they were adapted in part from the CPO.

The CKO needs to make sure that the length of their documents are not overly long, thus making it onerous for their members to read through, yet not too short and thereby perhaps skip over important information. Such decisions must be made through regulatory committees of the CKO. This is a difficult task and other than including guidelines for each standard there currently is nothing that would suggest the CKO needs to make drastic changes in this area to ensure their documents are concise.

Theme Six – Commentaries

This theme addresses commentaries within practice standards and guidelines as a method for educating kinesiologists with examples of issues they may face.

Within the profession of nursing, commentaries are seen as a useful tool for providing help and guidance on ethical issues that nurses may face (Pattison, 2001). Within the practice standards and guidelines of the CKO there is a good use of examples to explain some of the complex topics and issues. Within several paragraphs in each document one may find one sentence examples that just add a bit of clarification to the topic at hand. For example within the standard for consent it explains that consent may be written, verbal or implied. Implied consent is also mentioned and should be used with caution because it can be easily misunderstood. This standard then provides an example stating that a client who disrobes upon request may not be consenting to touching.

Therefore, consent as to the location and extent of touching must also be explicitly granted.

However useful single sentence explanations are, I recommend that the CKO include more scenario based examples and in-depth commentary. Only within the professional boundaries standard can one find scenarios for potential ethical issues that kinesiologists may come across in their practice. This standard provides scenarios for items like self-disclosing which has to do with how much personal information you share with a patient; giving or receiving gifts because some cultures find it extremely offensive to reject gifts even though it is often considered professional misconduct to accept gifts in our culture; dual relationships which have to do with having a personal and professional relationship with a patient; ignoring established conventions which could include meeting patients in unconventional, inappropriate settings (e.g., a restaurant); and sharing personal opinions which has to do with using one's professional status to convey an opinion or personal value to a patient. As one can tell from these scenarios, there is room for error due to inexperience or a lack of knowledge of standards and guidelines that could cause a kinesiologist to consciously or unconsciously commit professional misconduct. For this reason, scenarios should be present in all documents where there is a possibility for professional misconduct, detailing common professional misconduct issues like the ones stated above that kinesiologists may commit. Including scenarios within the standards and guidelines of the CKO may allow kinesiologists to better relate to professional topics and issues pertinent to their practice and foster deeper ethical reflection (Pattison, 2001).

Theme Seven – Experienced or Inexperienced Kinesiologists

When addressing the use of practice standards and guidelines, would it be safe to say that they are just as useful for new graduates as they are for experienced members? This theme was generated on the basis that professional standards and guidelines are long and complex and to understand this material one has to be a legal expert (Eriksson, Hoglund & Helgesson, 2008). Few practicing kinesiologists have taken full courses in professional ethics and legal issues. Much of what they learn they pick up in the workplace which suggests they may have some understanding of the CKO's standards and guidelines. New graduates who have taken at least one course in healthcare ethics have an advantage and may be better prepared to decipher these documents. Fortunately, regardless of experience level, all kinesiologists who become registered with the College must successfully pass an online jurisprudence e-learning module. This module reviews and tests legal topics relevant to kinesiologists who need to practice safely and competently. This module ensures that all kinesiologists, regardless of age or experience have met minimum standards in terms of how to conduct themselves ethically and professionally in the workplace. Having the jurisprudence e-learning module as a requirement has provided a minimum standard of knowledge and experience among kinesiologists that may not have been present before the profession was regulated. However, one could argue that such basic training is insufficient to meet the professional challenges and responsibilities of regulated kinesiologists. Further research beyond the scope of this study would be required to support this point.

Theme Eight – Ethical Orientation

Based on my readings of the practice standards and guidelines of the CKO, I have come to the conclusion that they are based primarily on a deontological perspective.

Deontology refers to an ethical position that states one has a duty or obligation to follow the rules in order to behave correctly and be morally right (Beauchamp & Childress, 2001). The CKO's standards and guidelines however are not this strict because there are several circumstances in which rules may be stretched or broken when there are conflicting concerns and one may override the other. For example, when patient autonomy conflicts with establishing the competency of patients. However, for the most part the documents reflect a deontological stance.

One may therefore ask, is deontology the right ethical theory to form the basis of these documents? Even though we are addressing standards and guidelines that were developed based on legislation, there is still an underlying orientation, which depicts how the CKO wants the standards and guidelines to be followed. An ethical orientation or theory is a very important part in determining how kinesiologists should respond to different situations. A deontological stance means that emphasis is placed on following the rules (Beauchamp & Childress, 2001). This limits practitioners who may assess ethical situations and make decisions based on their personal values in order to arrive at the best course of action. Another ethical theory called teleology emphasizes doing what is right based on the consequences that a decision produces (Beauchamp & Childress, 2001). This often means basing decisions around what will produce the most positive value or possible disvalue (Beauchamp & Childress, 2001). Unlike deontology, teleology considers the consequences of one's decisions and actions with significance placed on the ends rather than the means to reach those ends. Another ethical theory involves a care-based orientation. A caring orientation refers to the development of mutually beneficial relationships between people as opposed to focusing on obligations to rules, means or

consequences (Hadjistavropoulos, 2011). Hadjistavropoulos argues that the best orientation for promoting education is the teleological perspective because there is an emphasis on understanding the consequences of every action.

Overall the standards and guidelines under this theme present aspects of each of these three ethical orientations with a greater emphasis on deontology. The majority of the standards and guidelines concentrate on following the rules outlined by the legislation. Developing the standards to be more teleological may better educate kinesiologists by stressing the consequences of different types of professional misconduct and this may make a greater impression and serve as deterrence to act in certain unethical ways. This change would teach kinesiologists to look at situations from different perspectives to get an idea of which will result in the least amount of harm or the best outcome, as opposed to rigidly following a rule to merely avoid punishment which is based on the deontological perspective.

Theme Nine – Public Comprehension

Within research it is important for participants to comprehend all aspects of the research they are participating in. An emphasis is placed on ensuring that consent forms and surveys are presented at a readable level to the potential participants. Similarly, this level of comprehension should also be a consideration when developing practice standards and guidelines because their purpose is in part to inform the public of the responsibilities of kinesiologists as registered healthcare practitioners. Since the standards and guidelines are drafted from legislation it may be difficult to simplify every term used. With that said the CKO documents are much more understandable when compared to the professional misconduct regulations, yet they are still not as clear as they could be. The

documents are written in a legalistic tone which may make it extremely difficult for the public to comprehend their content. Also, when one considers that there are ambiguous terms within the standards and guidelines, as mentioned earlier, that may be problematic for kinesiologists to understand, how much more difficult will this material be to comprehend when read by the public?

A lack of comprehension for the lay person may also deter the public from reading the standards and guidelines to learn about the responsibilities of kinesiologists and what sort of care the public ought to expect. For example, the practice standard for consent mentions those who are guardians and trustees of patients. Such designations may have difficult to comprehend legal ramifications for those who are asked to make decisions on behalf of patients. Perhaps a version of the standards and guidelines should be adapted for the public and this would encourage people generally to learn what they should expect from kinesiologists. The College therefore needs to either develop a summarized version of the standards and guidelines directed toward the public, or perhaps simplify the academic and legal jargon that is currently being used.

Theme Ten – Guidance

The final theme that was identified for assessing the practice standards and guidelines of the CKO is guidance. More specifically, do these documents provide adequate guidance for kinesiologists when they are used? After reading these documents several times I have come to the conclusion that they do provide useful guidance for kinesiologists. The documents cover all the major areas in which professional and ethical issues within kinesiology may occur. There are some ambiguous words within the documents but besides that they are fairly comprehensible for kinesiologists. The

documents as a whole along with each individual standard and guideline are presented in a practical manner and it is relatively easy for kinesiologists to find specific topics. The documents are easily accessible and, thanks to the jurisprudence e-learning module, should not be difficult for any kinesiologist to read and interpret. Although the standards are sometimes seen as authoritative as opposed to supportive, the guidelines provide helpful clarification and guidance to help kinesiologists fully understand a particular topic and adhere to sound professional practice.

When it comes to developing the very best standards and guidelines, no documents will ever approach perfection. With the passage of time, as the profession of kinesiology grows and adapts to changes in society, the CKO practice standards and guidelines will be revised and expanded. The College has committees to solicit input from stakeholders on a regular basis to review documents with the goal of improving its regulations. There are issues like misinterpreted terms and lack of concrete examples to demonstrate how ethical decision making is applied that need to be addressed within the CKO's standards and guidelines. For the most part, however, its members should have few problems reading and understanding this material and utilizing them to ensure that kinesiologists practice safely, competently and with a high level of professionalism and ethical integrity.

Document Analysis of the CKO's Code of Ethics

Theme One – Misinterpretation of Key Terms

One of the major issues I found within the CKO's code of ethics is the number of ambiguous words. Like the standards discussed in the previous section, the code of ethics begins with a definition. The definition states "The ability to make appropriate ethical

decisions that are in the best interest of patients/clients is an essential aspect of professional practice” (Transitional Council, 2012, p. 1). Nowhere in this definition or in any other part of the code of ethics does it state what is being defined. Is this the definition of a code of ethics? Therefore the code of ethics provides one definition for its members, but does not tell them what they are defining. It is also unclear if the terms “patient” and “client” are to be interpreted as the same or different. They are used interchangeably within the above definition, but only the term patient is used on its own in the rest of the document as in the following, “members are at all times guided by a concern for the patient’s well-being” (Transitional Council, 2012, p. 2).

The document then goes on to state that they have adopted a values-based code of ethics, but does not provide a definition for what a values-based code of ethics is. It is assumed that kinesiologists will know and understand what this is. The term dignity is once again used in this document without a definition or statement regarding how it is to be interpreted. The code of ethics refers to kinesiologists having a concern for a patient’s well-being. With no definition of well-being provided, what exactly does the code refer? Is there a concern only for a patient’s physical well-being or perhaps mental well-being, or both? Other ambiguous expressions within the CKO’s code of ethics include integrity and moral imagination.

Not including a definition for these terms may lead to disagreements between practitioners about ethical issues on how to properly interpret the code of ethics. It is important that the CKO’s regulatory committees provide definitions for words that can be misinterpreted so that kinesiologists can adequately understand and apply the code of ethics to ethical problems.

Theme Two – Patient-practitioner Focused

The code of ethics developed by the CKO concentrates solely on the therapeutic relationship. It makes only a brief reference to any other type of relationship as this statement indicates, “The ethical values for kinesiologists should be applied to in all aspects of professional practice, particularly in the patient/client relationship and when facing an ethical problem or dilemma” (Transitional Council, 2012, p. 1). This is also clear in the fact that the term patient, which is associated with the therapeutic relationship, is used eight times in this two page document. There is no specific reference to any other type of workplace setting or role, even though kinesiologists are not all working in therapeutic settings. Some may work for insurance companies while others may work with WISB claims for private employers or in disabilities management.

The CKO’s code of ethics needs to be expanded to include information for other kinesiologists who do not work exclusively with patients. This could mean extending the length of the code of ethics or even drafting a separate code of ethics for non-therapeutic relationships.

Theme Three – Practical Presentation

Addressing the practicality of the CKO’s code of ethics was relatively easy since the document is only two pages long. The document begins with a definition and then an overview of the document itself. Next it describes five principles and then describes its decision making model (see Appendix K). The document is presented in a practical manner, making it quite easy to navigate and understand. Nurses, for example, believed that it was important for codes to be presented in a practical way and be applied

efficiently and effectively when confronted with ethical problems (Verpeet, Casterle, Lemiengre & Gastmans, 2006).

Because the document is already presented in a user-friendly manner there is no need for changes to be made. However, perhaps some necessary adjustments, like concrete examples to demonstrate how the decision making model is applied, would be part of any future changes the CKO makes to its code of ethics.

Theme Four – Supportive or Authoritative

After carefully reading the CKO's code of ethics I have come to the conclusion that the document is supportive of guiding kinesiologists to make good ethical decisions, rather than dictating from an authoritative stance how kinesiologists should make moral judgments. The majority of the statements throughout the document are open, leaving kinesiologists to decide for themselves rather than stating strict answers for dealing with an ethical problem. For instance, the document states that by adopting values and a standard process for analyzing situations, kinesiologists are in a position to make the best decision possible. The document also states that the goal of providing a stepwise decision-making model is to make kinesiologists feel more secure in their ability to make the best decision and encourage kinesiologists to use other models if it would make them more comfortable. This is not always the case with every profession. Codes in nursing should play a regulatory role rather than a prescriptive role (Hubert, 2004). Hubert reiterates something similar two years later when stating that codes of ethics are meant to be supportive, because their goal is to develop their member's understanding of what their responsibilities are as registered health practitioners (Hubert & Murphy, 2006).

I agree with the College developing a supportive code of ethics because it is important for kinesiologists to know that some ethical problems are complex and cannot always be solved with a simple, straight forward answer. On occasion, it can take considerable time to think of a morally good course of action.

Theme Five – Brevity versus Thoroughness

Before comparing the CKO to other healthcare professions (nursing and physiotherapy) my opinion of the CKO's code of ethics was that it is overly short. It contains only the most basic information and needs to elaborate on several items including its decision making model, its ambiguous terms and how to incorporate values into decision making. When comparing the CKO's code of ethics to the College of Nurses of Ontario's (CNO) code of ethics, I found that the CNO's code of ethics was more robust. The CNO provides several definitions for words like nursing and client. They specify how to incorporate these values into one's care for a patient and provide several scenarios, giving nurses examples on which to base their ethical decisions. To provide a sense of how much more comprehensive the CNO's code of ethics is in comparison to the CKO's code, the CNO's code is 21 pages whereas the CKO's code consists of two pages.

However, the CKO's code of ethics so closely resembles the College of Physiotherapists of Ontario's (CPO) code of ethics that I find it safe to say they are one and the same. Despite the CKO having a code of ethics identical to the CPO, I recommend that the CKO add some much needed information to its code of ethics. I suggest including definitions for several ambiguous or frequently used words, provide scenarios that are specific to ethical issues kinesiologists face, as well as include more

information on how to properly use and incorporate the code of ethics when addressing an ethical problem.

Theme Six – Prioritizing of Principles

This theme will address whether or not the principles outlined in the CKO's code of ethics should be prioritized or ranked by importance. The CKO's current order of its list of principles is: respect; excellence; autonomy and well-being; communication, collaboration and advocacy; and honesty and integrity. Ranking ethical principles does not provide any clear evidence as to whether or not it produces better resolutions, but in one study it was shown that medical residents who relied on ranked principles came to a conclusion faster when faced with an ethical problem than if the principles were not ranked (Williams, Hadjistavropoulos, Malloy, Gagnon, & Sharpe, 2012). Prioritizing or ranking principles, therefore, could be beneficial for kinesiologists, considering that many have no formal training in dealing with ethical situations. A ranking of principles may make it easier to sort out difficulties when dealing with a particular ethical situation. For example, at the level of patient care, it would seem that autonomy and well-being are the highest priorities. Kinesiologists treating patients would therefore have to ensure this principle is reflected foremost in all their encounters with patients. However, the problem with prioritizing ethical principles is that one cannot predict every ethical problem that one will face because one may come across an issue in which ranked principles do not produce the best course of action. Therefore, I think it is in the best interest of kinesiologists that principles be prioritized depending on the context. When treating patients, autonomy and well-being are the highest priorities, but in other situations other

principles may be ranked higher. Such flexibility would allow kinesiologists to deal with ethical issues on a case-by-case basis.

Theme Seven – Ethical Growth

Is the CKO's code of ethics designed to promote the ethical growth of kinesiologists or is it strictly a tool for discipline to avoid malpractice charges? I interpret ethical growth as someone improving in their ability to identify, address and resolve ethical issues with good moral reasoning skills and judgments. Ethical growth however is not always achieved or promoted through codes of ethics. A code of ethics may in fact deter nurses from using independent critical judgment and discernment that is important for making good moral decisions (Pattison, 2001). Pattison goes on to assert that codes of ethics do not teach nurses to behave autonomously and that they use the code solely as a tool for discipline and to avoid misconduct rather than as a learning tool.

It is difficult to determine if the CKO's code of ethics provides ethical growth or not. I find that its supportive style and decision making model do portray it as an advocate for ethical growth yet the lack of specific material and detail provided within the code of ethics make it difficult for kinesiologists to get much valuable information out of it.

Theme Eight – Commentaries and Applied Examples

As mentioned earlier, commentaries are seen as a useful tool for providing help and guidance on ethical issues that nurses may face (Pattison, 2001). I find this to be one of the biggest problems I had with the CKO's code of ethics. There is no information regarding commentaries, explanations and suitable examples within the document and therefore no resources for proper use of the stepwise decision making model. Without

even one example or case, it is difficult for kinesiologists to get an idea of how to properly use the decision making model and how to apply the principles to an ethical issue. Pattison (2001) makes the point that perhaps ethics education through codes of ethics should be carried out by providing examples and models for nurses to follow. Perhaps codes of ethics should be more limited in scope, allowing for other forms of education to promote moral judgment and awareness.

Pattison (2001) provides an interesting point, yet I still recommend that the CKO provide several concrete examples of ethical problems that may arise in the workplace so kinesiologists may have a template for the thought processes involved when addressing similar or even different problems. I would recommend adding a section for specific commentary and examples to the code of ethics, or providing referrals within the code of ethics to find appropriate information and resources that clarify and explain how the code should be used effectively.

Theme Nine – Perfect Kinesiologists

This theme deals with the idea that a code of ethics can have ethical expectations of healthcare practitioners that may be too high and unrealistic. Nursing codes of ethics set a mandatory minimum ethical behavior that often require nurses to go over and above what should be expected of them (Pattison, 2001). Pattison states that nurses are not provided the resources to properly interpret codes and apply them seamlessly to specific ethical situations. Moreover, since an ideal level of ethical conduct is often unattainable, there is a possibility that nurses will not take ethical behavior seriously in the workplace (Pattison, 2001).

The CKO's code of ethics has done an excellent job in terms of not setting the ethical standard too high. It promotes doing the best that you can, making the choice that you believe to be the most ethically appropriate for each situation. For instance, in the summary section the code of ethics states that even though there may be a difference of opinion and a final decision may not benefit all, it encourages kinesiologists to try their best to make the best decision possible (Transitional Council, 2012). This code of ethics allows for discretion and is realistic in terms of how to resolve ethical issues. For example, the document states that kinesiologists will probably experience some form of discomfort when trying to resolve an ethical situation and that it is unlikely that everyone will agree with a particular decision (Transitional Council, 2012).

Theme Ten – Level of Experience

It is important to determine if the CKO's code of ethics requires a certain level of experience in order for someone to understand and interpret it. The level of experience required to properly utilize the code of ethics is different from work experience. Kinesiologists with general work experience are able to resolve the majority of their ethical issues without the use of a code of ethics. However, were kinesiologists to have experience in using a code of ethics and its decision making model better moral reasoning would occur. In my kinesiology undergraduate program all students were required to enrol in a healthcare ethics course. Within this course they learned how to address ethical problems with a step-by-step decision-making model. Therefore recent graduates from university should gain experience from utilizing a step by step decision-making model and apply ethical principles in that process. This however may not be the case for kinesiologists who have been out of school for a time. Many practicing kinesiologists

have not received any formal ethical training courses in university and therefore they base their ethical decision-making on experiences in the workplace as opposed to using a decision-making model which the CKO now insists upon.

Perhaps the College needs to revise its competency profile to ensure all kinesiologists have course background in healthcare ethics. Or, the CKO can require kinesiologists receive such experience through other forms of education, like workshops or online courses. Such efforts would advance the knowledge and experience kinesiologists have with healthcare ethics, codes of ethics and the application of ethical decision making models.

Theme Eleven – Ethical Orientation

Ethical orientation refers to the ethical theory or theories that serve as the foundation and influence how codes of ethics are to be used and interpreted. Hadjistavropoulos (2011) identifies three prominent ethical theories within codes of ethics. They are: deontology, teleology and caring. It was determined previously that the CKO's standards and guidelines were created primarily from a deontological perspective. However, there are elements in the code that reflect caring and teleology. From a caring stance the code of ethics encourages strong relationships be formed with patients because they are the recipients of healthcare services. The emphasis of the code of ethics is primarily focused on what is best for the patients. Also, making it clear that the College wants to ensure the greatest good or benefit is provided to patients shows that the kinesiologist-patient relationship is highly significant. I believe that when patient care is seen as a foremost concern for kinesiologists the public image and credibility of the kinesiology profession will improve substantially.

Parts of the code of ethics are also presented from a teleological perspective as the code of ethics states, “Although there may not be complete agreement on one unique line of action, some actions will be more defensible and others will be less defensible” (Transitional Council, 2012, p. 1). This encourages kinesiologists to try and make the best possible decision because it requires them to weigh consequences of each possible scenario and see which action produces less harm and the most benefit. However, I do not see the code of ethics as teleological overall because the document emphasizes patient rights, autonomy and consent as the highest values that must be met. There is little to no sense of utilitarianism, meaning that the code of ethics is not trying to provide the greatest good for the most people, it mainly focuses on what is best for the patient.

Currently, under the deontological and caring orientations, the CKO is mostly concerned with providing the best care for patients to build public trust and promote the profession’s image. Perhaps the code of ethics should include some teleological aspects because ethical problems and decisions involve other relevant stakeholders besides an exclusive focus on patients. For example, when addressing certain ethical issues, kinesiologists should consider how judgments will affect patients, as well as family and friends, companies and organizations, and even the general public.

This review of literature presented a short history of healthcare ethics, the evolution of kinesiology in Canada, and ethical issues in kinesiology. It carried out a qualitative document analysis (QDA) of the CKO’s practice standards and guidelines, and its code of ethics to inform the reader about new regulations that guide the practice of kinesiology in relation to ethics and professionalism.

In the next chapter, the interview data or the findings of the study will be analyzed through an interpretive description (ID) approach. The goal of this analysis is to identify any emergent themes or recurring patterns in the data. Verbatim quotes from the participants of the study will be presented to support the identification of the themes.

Chapter Four

Analysis of Findings

After collecting and transcribing the responses of interview participants, and providing the participants with transcripts of their respective interviews to make any corrections and revisions, the data underwent an interpretive description (ID) analysis. This analysis entailed reading and re-reading the transcripts, coding similar phrases or terms, abstracting from these expressions to create categories, and eventually identifying major themes that capture significant insights about the perceptions of kinesiologists regarding ethics and professionalism generally and as established by the College of Kinesiologists of Ontario (CKO). The results of this analysis produced eleven emergent themes. This chapter will present a brief overview of each theme and demonstrate how relevant participant verbatim responses led to and support the identification of the themes. The themes will be discussed further in chapter five.

Theme One: Glorified PTA/OTA

Since becoming a regulated profession, one of the major concerns noted by kinesiologists was to no longer be seen as a glorified PTA (physiotherapy assistant) or OTA (occupational therapy assistant). Glorified PTA/OTA refers to being seen as nothing more than an overqualified assistant, required to simply follow the instructions of a physiotherapist and to carry out their prescribed exercise routines with patients. As physiotherapy assistants, kinesiologists are not to assess a patient's level of improvement or lack thereof and then make changes to his or her program based on that assessment. By contrast, regulated kinesiologists do have the skills and training to be given a patient with

a diagnosed injury or illness and to work with that patient, adjusting her or his program week by week without the supervision of a physiotherapist.

Five of the 11 kinesiologists interviewed had some issue with the idea of being grouped with and/or used as a PTA/OTA. Some stated that they felt as though kinesiologists were under appreciated and undervalued in terms of their capabilities. They did, however, see a promising future for their profession. Now that they have become regulated, they are slowly moving away from being seen as PTA assistants and are developing into full-fledged healthcare professionals. When I inquired about what the participants thought about becoming regulated and how they believed other healthcare practitioners perceived the regulation of kinesiology, these were some of their responses.

P3: Our kinesiologist here. A lot of times she says you know what I'm just a glorified physical education teacher. And she said "this isn't what my skills are for." So that is disheartening when I hear things like that. So, just because her skills aren't being utilized like they should be and so we have a physiotherapist that is coming in and setting the plan and she is just facilitating it.

P2: We had meetings to discuss this and it was my understanding that now that I was going to be operating as an independent healthcare practitioner, the days of being a glorified assistant were over.

P6: And also realizing that kinesiologists are valuable and that there shouldn't be kinesiologists out there who make next to nothing at a clinic. You know? – Being a physio aid essentially and that. They have a lot of value to them and I don't think that is out there and I don't think they see that. I don't think the rest of the healthcare practitioners do either.

P11: I think it very much is and it is frustrating because obviously there's a big gap in the education and our expertise so I do agree that at many clinics, I know not all of them, but many clinics do get kind of bunched in that category with the physio assistant. I think it is kind of inappropriate just with the education difference and or expertise where we should be completely separate and we shouldn't be seen as the same.

P11: You go looking on job sites and they'll ask for physio assistant/kin and they just class them as the same. And I think a lot of places really don't realize the difference, or that there is some sort of registration with the kinesiologist now and along with that goes the pay grade where a physio assistant should be making a lot less than a kin or vice versa where a kin should be making a lot more than a physio assistant, but because those two professions get clumped together the salary rate kind of gets clumped together as well.

Theme Two: Training from CKO/OKA

When asked about post-graduation ethical and professional training in kinesiology, four of the 11 participants thought it would be beneficial if the CKO or the Ontario Kinesiology Association (OKA) could provide ethical and professional training through continuing education courses. Now that the profession is regulated, there is a greater need for ensuring that kinesiologists, as healthcare professionals, maintain their level of expertise and knowledge as they are trusted to work as self-regulated practitioners. This means they are not required to have an immediate supervisor who oversees their work, and yet they must protect the public from harm. Participants have found it difficult to find continuing education courses and believe that the CKO or OKA

should provide more courses on ethical and professional development. Furthermore, those who do discover continuing education courses found it difficult to travel to Toronto because few or no such courses were offered in Ontario outside of this area. The following are responses to questions that asked participants about their level of ethical and professional training.

P4: Should it be provided by the College, or maybe OKA? I think that's something that could be, should be beneficial to everybody.

P9: It would be wonderful if they had something like sample, case samples posted or frequently asked questions on their website for things that might arise in an assessment and you know a resource of some sort.

P9: I think there was a course offered at one time or a presentation through the College's lawyer, it was years ago but it was called record keeping and it also talked a bit about files... not just taking notes and stuff but how to save your electronic records and stuff like that and how long should you save that stuff, who can access it, you know to protect the information and that was really practical and helpful, so I would like to see more of that.

P9: I find it is a little weak right now for opportunities. I see some coming through, it would be nice if more options were available and resources for that.

P10: Even just as continuing education sort of thing if new things come up or new situations arise where, you know, there are lots of new things like social media I am sure that people are getting involved with anyways so...

Continuing education is an important aspect of every regulated health profession in Ontario and evidently, kinesiologists would like to see more opportunities for their

professional and ethical development. It does not matter if such instruction is provided by the OKA or CKO, as long as it provides a quality experience and is conveniently available.

Theme Three: University Education

One of the most talked about subjects among the participants was about kinesiology students and their university education. Ten of the 11 participants made comments regarding this topic. Several major concerns arose from this discussion. Eight of 11 participants expressed how it would be beneficial to have hands-on experience as undergraduate students in university. Many kinesiology students acquired theoretical knowledge, but were not equipped to apply that theory to practice. The following were responses when participants were asked about clinical experiences and practice as part of their education.

P2: So we're going to struggle for quite a while, until we get more kinesiologists out there working, to be able to be mentors. But, in order to be a respected healthcare profession we need clinical settings for kins.

P7: I was really lucky that I had a job in the field, all throughout my undergrad so I was able to apply the knowledge I was learning in school while I was learning which was amazing for me but I had a lot of friends that graduated and had no clue what they learned and I mean they got good grades but they just didn't know how to apply it.

P8: I believe there is still a bit of disservice out of the universities that I think because it is a university body, were less so into the hands-on and less ability to get the hands-on training. And so I think those trying to graduate with just their

degree and want to go out and practice, they might not have all the tools so there might need to be – you know these are the other kinds of sessions and courses and that that you need to go out and do or other college portions or something to really round out what their application of the kinesiology philosophy is.

P9: I am coming from a co-op perspective so I am 100% being the co-op experience, it really, really was helpful to kind of know what you are getting into and what sort of speciality you're interested to work in, so yeah I think that is great.

P11: There should be that heavy, practical aspect to the course that not all schools have. Where I did some internships through my university which were definitely helpful to kind of get you in the groove of implementing that kind of practice idea.

Another important point that several kinesiologists were in favor of was implementing more ethical training and education in university programs. Participants felt that a healthcare ethics course should be required within the four-year degree program in kinesiology. This would better prepare kinesiology graduates to understand ethics and professionalism and learn about the regulations and relevant documents on these topics as established by the CKO.

P1: Umm, but probably coming out of university now as a new grad they're going to have to have done a little bit more work in it because if they're coming straight from new grad into becoming registered and working for themselves or working on their own as a kinesiologist, it would benefit them to have more for ethics.

P5: Definitely a course on just professional conduct alone and ethics, that is important. Of course the hands-on is important. A good component of just having them exposed to different areas, different parts, different areas where kinesiologists are employed or are needed.

P7: Umm, I would definitely like to see some ethics courses specifically for kinesiologists at the university level. That would be great.

P9: Ethical, legal and you know what is best for the client and also the evidence based like report writing and that sort of thing.

P10: I believe that they could probably do more on ethics because I think I only took one ethics course in my 4 years. I know they touched on them in year 1 and 2 basic kin prerequisites but I think maybe going into more depth on those, having more of an umbrella – and linking them to the College, you know, understanding what the College's expectations are for code of ethics and then just ethics in general. You know, I think that that would be a good segue into the College.

Finally, the two points above, hands-on practical experience and a mandatory healthcare ethics course as part of one's university education in kinesiology, led to a third point made by participants. Namely, that there needs to be more consistency and standardization of degree programs at the university level. This would ensure that students who wish to write the CKO's entry to practice examination and become members of the College are equally prepared and have the same chances for success no matter what university they attended. The following are additional responses when participants addressed the topic of university education.

P1: But, I think a lot of the universities – because the universities aren't standardized, so that's an issue.

P2: If I knew going into university the chances were that I was going to be a registered kinesiologist that is the stream that I would have taken. As opposed to getting through my studies and all of a sudden there is this college now that's governing over me and I hadn't received any training previously, I felt a little lost out there.

P2: But I also understand that this is just part of the initiation of the college. I got caught in the grandfathering in, but if I was a student today, I would certainly want an opportunity to take some training at the university level in order to prepare me for the regulation.

P6: It needs to provide more information for kinesiologists coming out, but it needs to be done in the first year, it can't be done in the last year before they graduate. They have to be aware of where they can go, how they can advance, the ethical issues then, the morality, whatever, should all come as some kind of an introduction prior to.

P11: It would definitely be good to see a little bit more standardization between – from school to school. I went to a smaller school so we obviously didn't have the resources that some of the other schools had. But just talking with people that went to other schools, some of the different courses and things that they took were very different from kind of the things that we learned and I think that there should be that kind of mandatory set of courses that you need for being registered and having that kind of background that need just for one preps for the exam itself for

the registration. Because I found that there really wasn't anything that I learned in university on that exam.

A kinesiology degree is the foundation from which kinesiologists draw their knowledge. The participants in this study believed that with the regulation of kinesiology, university education in kinesiology should include more clinical experience, a required healthcare ethics courses, and a standardized curriculum in kinesiology in all universities. When looking at these three issues, there is a clear connection between them. Universities are not properly preparing students to become registered kinesiologists in these areas. As such, many kinesiology students do not acquire sufficient knowledge about ethics and professionalism and have little experience with ethics in action in the workplace. Clinical experiences could potentially help kinesiologists engage in identifying and resolving real ethical problems in the care of patients or when dealing with patient records. For example, the ethical implications of the misuse of equipment when treating patients or improper therapy plans can only be fully appreciated in the workplace. More specifically, using the wrong settings for an ultrasound machine or improperly conducting range of motion exercises could call into question one's competency. Having practical experience, taking a healthcare ethics course and being enrolled in a standardized university kinesiology program, would enhance the competency and ethical preparedness of kinesiologists before they become members of the College.

Theme Four: Similar Ethical Standards

When asked about their knowledge of the CKO's practice standards and guidelines, and its code of ethics many participants stated that much of their knowledge, if not all of it, came from the jurisprudence e-learning module. However, with further

probing I found that most of them also believed that the practice standards, guidelines, and code of ethics of the CKO are very similar to other Colleges like physiotherapy, chiropractic, and nursing. Participants of this study believed that not much changed from pre-regulation to post-regulation in terms of the CKO's documents that they must now adhere to because when they were not regulated they had to follow the standards, guidelines and codes of other regulated health professions. Four out of the 11 participants had something to say about the similarity of the documents among various health professions.

P2: I don't think it would have been a difficult transition. From my understanding of the other colleges, you're looking at OT, PT I think ours was pretty much frame worked on theirs, so I don't think it would have been a difficult transition.

P2: Ethical knowledge I think can almost be caught with a broad paint brush. If you are looking at anything working with regulated healthcare professions, most of it will fall under the same training, so I don't think we need to re-invent the wheel.

P5: Right now I don't think I would change anything. They're very similar and they mimic like the nursing, the college of nursing as well as all the other colleges that I've read through and they've done a good job, so I don't think I would change anything right now. They've got a series of councils and committees that sort of help through the process should any issues arise.

P11: I would assume that they are very similar. I haven't read over the chiropractic standards, but like I said before they wasn't much difference from pre-registration to post-registration.

Theme Five: The Jurisprudence E-Learning Module

The jurisprudence e-learning module requires all members of the CKO to go through a step-by-step tutorial of the laws and regulations regarding kinesiology and its practice in Ontario. As the jurisprudence tutorial is mandatory for all kinesiologists, and seeing as how I interviewed only those who were registered with the CKO, everyone had something to say about the tutorial. There were different aspects of this teaching tool that participants thought were good and bad. Many saw the length of the tutorial as too long and some believed it provided somewhat redundant information. Several kinesiologists referred to the jurisprudence e-learning module as common sense. It did not require much knowledge to complete and was boring at times. Others, however, saw it as a necessary refresher and enjoyed learning from it. The following are participant responses regarding the CKO's mandatory jurisprudence e-learning module.

P1: Was very thorough, and long and boring and a lot of it was quite repetitive and common sense.

P1: Okay, as someone who was grandfathered in, the jurisprudence was absolutely atrocious to sit through.

P3: I enjoyed it; I think I learned a lot from it. I think it was very engaging and had multiple different learning strategies in it.

P3: It wasn't difficult. There wasn't any "new information learned from it" but it was a nice reminder of information that you may have forgotten or just a reinforcement.

P4: So in having it as a requirement before you become regulated was essential. Learning the background in legislation, learning background of everything, reasons why.

P5: Very thorough, very long, tedious, but all the information in there is relevant. It is almost like teaching a little kid on it. And I liked it. It was easy to understand, it was tedious, it was long, but it was worth it, I thought.

P6: In some cases there was not the clarity there but I think they did that on purpose in order to challenge, but, I know they were trying to stay within scope, but it could have been a little bit more generalized, with respect to ethical issues similar to the disability act and that.

P11: I would say it was sort of redundant. It did go through different sections each time so it was like all the same things. It was more so – a lot of it was just stuff that you wouldn't do or that you know not to do anyway.

Theme Six: Referring to the Standards, Guidelines and Code of Ethics in Practice

The importance of developing standards, guidelines, and a code of ethics is to ensure that all members of the CKO practice safely and ethically. These documents provide valuable information to kinesiologists, serving as guidelines for what to do and what not to do with regard to the practice of kinesiology. Figuring out how often they are referred to will give us a better understanding of how useful they are to kinesiologists. Eight of the 11 participants had something to say about how often they referred to the CKO's standards, guidelines and code of ethics. There was very little use of these documents. Four of the eight participants mentioned never having referenced the documents for the purpose of resolving or inquiring about an ethical situation.

Furthermore, those who said they did refer to the documents had only done so once or twice. Yet, kinesiologists acknowledged the importance of the documents even if they did not often use them during work. They believed that even though one did not consult the documents too often, these regulatory guides and code still influenced how one practiced. They also felt that the documents were necessary sources in case one did encounter an ethical or professional problem in the workplace.

P1: Now there are more definite guidelines and I think it is better for the profession on the whole. Especially when it comes to other disciplines who may cross into the scope of kinesiologists such as personal trainers. So this gives us a better handle on what we do and how we are trained, and in protecting the public.

P1: No, I have had to refer to it. Because I don't know what my proper designation is in various situations, because I work as a personal trainer and I work as a kinesiologist. And, when I can use one and not the other and when I have to use both.

P3: Because I'm not working privately, or not working on my own, I have to follow the code of conduct with my employers here and so that is the ethical standard that I need to adhere to and I would say that our standard here is probably higher than what the College has put out. So it hasn't impacted me.

P5: Not yet, no but I am sure if I were just an entry level kin I would probably refer to it.

P6: No, I do think you need to look to it when you get to specific situations and that, but they are not going to be the run of the mill situations. So that is kind of the thing. That's why you have the knowledge before, it's just this is more

specific so when you get in that tight spot you have that reference or resource to go to or you can call the College or look it up.

P10: I think it influences my practice a lot. As far as doing any change like you said, I felt I had pretty decent charting and everything leading up to this but going forward I think it is going to be good to have as a good reference if I did come into a conflict situation that I didn't know what to do with, or what should be done if you are in a situation where you observe malpractice or feel the need to file a report on another practitioner.

Kinesiologists may not be able to recite pages from the Standards and Guidelines, but that does not mean that the knowledge is not there. Referring to the jurisprudence e-learning module as common sense means that what kinesiologists are learning is general knowledge that they already know and consider others to know as well. Referencing Standards, Guidelines and the Code of Ethics may not be that necessary if the information contained within them is already considered common knowledge.

Theme Seven: Quality of Standards, Guidelines & Code of Ethics

When asked about the quality of the CKO's standards, guidelines and code of ethics, nine of the 11 participants shared their thoughts about changes they would like to see. For the most part they felt that no major changes were needed, however, they believed the documents strengthened the professional image of kinesiology. With the various settings kinesiologists work in, some participants felt the focus of the documents was too general and they wanted to see more specific information from different areas. Having general information meant that the emphasis of the documents was based on general rehabilitative situations, leaving kinesiologists who work in other specialized

areas to be unsure how to apply some aspects of the documents relate to their respective work environments. The following are participant responses when asked about the quality of CKO documents pertaining to ethics and professional conduct.

P1: If we could just have like a little ethics guide, that would be wonderful. That would be perfect for me. Umm, because I know that it is all laid out for us, but if we could just have a little ‘*ethics for kinesiologists*’ that would work for someone like me.

P1: Umm, yeah I honestly think that the Code of Ethics, Code of Conduct all the standards that have been set are a big part of improving kinesiology as a practice. So, I am okay with any of the changes that they have made.

P5: I think they’re easy to understand. Again I think coming from a clinical background and having worked with physios and chiros for quite some time now and having gone through, it’s called an accreditation for my company. I am familiar with the Code of Ethics and the standards so I understand it pretty well and I think it is very helpful.

P5: I’d say from a scale of 1-10 I think they’ve helped me pretty well. I would probably rate it at an eight or nine. Like I had mentioned they’re still working on the relationship – the regulations between the practitioners and delegation between the practitioners, but yeah it has helped me quite a bit.

P6: So in that way there are big differences. A lot of the examples were very much based on rehab where there is that relationship between the patient and the kinesiologists regardless of whether it is ergonomics or health and safety and that whereas mine we don’t have relationship and we don’t establish a relationship at

all during the assessment it is very true. So there is nothing that way that was covered, from what I recall. So that is kind of where it stands. It just needs to look at all of the scope of a kinesiologist. I find that it is a narrow scope and there are things out there that I can't even think of that would happen in health and safety you know that they would be exposed to ethically as opposed to where I am now.

P8: I think they've nailed it, I can't think of any improvement. Yeah I thought it was excellent.

P9: I could see them trying to encompass everybody but the clinical does have a big part I think in terms of the examples and stuff. From my perspective with reporting and documents and dealing with peoples requests and their privacy and that sort of thing it is sometimes a little bit harder to find that type of information when it comes to ethics.

P10: So maybe more distinct to each person's designation and what their expertise is in, maybe honing in on something like that because maybe – my situations with patients here tend to be a little bit different than they were when I was at a motor vehicle, or WSIB treating those sort of things, so they are different and it would be nice to see if they could hone in on different peoples' expertise.

P10: Like I said I do treat palliative patients in their home and I've come across an experience where someone has passed away in my presence and that tends to be a very difficult situation for not only myself, but the family and so getting a little bit more training or just reasonable things to do in those cases.

P10: But it is – just a little bit more guidelines on protocol in regards to my profession. For example how someone in my practice would deal with a DNR (Do not resuscitate legal order) and things like that.

Theme Eight: Satisfied Ethical Knowledge

Eight of the 11 participants stated that they were satisfied with their level of ethical knowledge. Other participants went into more detail, contributing their satisfaction to their level of experience in clinical settings or to their successful completion of the jurisprudence e-learning module.

P2: I think I've received enough training through my prior workplace that any situation that arose, I knew exactly what to do.

P5: I am satisfied with my level of training since the colleges required a jurisprudence course that we had to do before registration. So I am confident.

P7: I have never taken a course just on ethics, just whatever modules I have had to take, so... most situations I can deal with on hand and if I am ever stuck I just look to someone higher than me.

P8: I think it strengthened some of my understanding and I am still learning of how to apply the ethics portion of what is absolutely the right and wrong, I think I have a good feel for it personally of what good ethics are.

P9: I am pretty satisfied but it is something to always – like I would like to see the kin perspective more. I think there was a little bit of it in the jurisprudence course with the kins that was pretty good with lots of case studies and examples and that sort of thing.

P11: My level of training I would say is kind of low to non-existent, it is just on that jurisprudence course. However, I do feel knowledgeable about the topic.

P11: I would say I am satisfied with it.

Theme Nine: Common Ethical Issues

Throughout the interviews I began to notice common ethical issues that kinesiologists mentioned when talking about ethics in the workplace. Six out of the 11 participants described ethical problems in relation to confidentiality that involved the notion of information sharing. Respecting the privacy of patients within one's clinic is important, even when it comes to one patient asking about another. Also, keeping a patient's health information confidential and not sharing that information with unauthorized people is highly significant as well.

P1: Umm... probably with information sharing – I've been called numerous times by personal trainers asking for client information. Which I am not permitted to give out without client consent. So that client actually has to come back to the clinic, sign forms and allow me to converse with that personal trainer before I can give their information. That and even just in office, cause if I pick up the phone and somebody asks me for information I can't give any. And people quite often do not like that.

P2: Well, on the street it is very different than it is in a clinical situation. As a registered healthcare practitioner I need to maintain the confidentiality of the patient I am treating. So I am not to give information. As innocuous as it may seem "is that Mr. Jones," – I can't be divulging information like that. Or for instance, "oh is that the guy I read about in the newspaper? Is that the guy that lost

both of his legs in that vehicle accident?” Well I can’t give that information out. Again it seems like very innocuous information, but to maintain my standards of care, I need to protect the privacy and the confidentiality of the patient that I am treating so I can’t give that information out. And sometimes the patient asking the questions would get frustrated with me and say well I know him off the street. My usual answer would be then if you know them, go and introduce yourself and ask them yourself if they are indeed that individual. But I can’t give any individual information out about that person. So that is probably the easiest one... That would happen on a daily basis.

P7: So I had to tell her sorry I can’t disclose that information and then she went up to our receptionist and bugged her and was like “I know about confidentiality. I am not trying to harass anyone.” So she was pretty upset that I wouldn’t give out everyone’s phone numbers because she has known these ladies personally for years and I just explained to her “I am sorry but you are just going to have to ask them for their phone numbers yourself.

P10: Or we constantly get asked if someone is not there, it’s like “oh where’s Joe, where is that person,” and we do have to say that we can disclose that information about them but also if someone wants to get in touch with them we can’t give out personal information about other members. If someone wants to go and approach people in the class it is pretty open to do that, but we don’t encourage people to – because there is of course our confidentiality policy and we do read and have our member’s sign as people come in to our programs.

P11: Yeah, you just chat with your patients and they will ask about other patients and that kind of thing but you normally just change the conversation and just don't answer their questions about other patients.

Another common ethical issue that five of 11 participants talked about was professional boundaries. This topic can refer to disclosing too much personal information with patients, to asking out patients, or patients asking kinesiologists out. There are professional boundaries all healthcare practitioners must maintain between themselves and their patients or clients so proper care is not compromised. The responses of kinesiologists who I interviewed talked about patients being attracted to practitioners as opposed to practitioners being attracted to patients. The following are their responses on the topic of professional boundaries.

P1: A lot of the times clients would like to know more about me because I mean if you're stuck in a room exercising with somebody for an hour or so, you're going to chat. But trying to keep people on topic is sometimes quite a challenge.

P4: So what I mean by day-to-day basis is that there is an ethical dilemma where by people get comfortable with you. You work with them you may be working with them through their accommodation. Maybe speaking to them when they are on a short term disability leave, they're disclosing stuff to you on the phone, you then become a container of knowledge.

P8: And we have to sign a confidentiality agreement for you know "what happens in the hospital stays in the hospital" and I am very aware of that even if I see people that I know from outside of my life here up on a patient floor or something I don't approach them unless they approach me, just to try and keep that

delineation of personal life and what I am doing here if it is not necessary that I interact with them.

P11: I had a patient ask for my number.

Theme Ten: Importance of Charting

Proper charting or note taking is an important aspect of ethics and professionalism as a kinesiologist. Seven out of 11 participants made reference to the significance of charting. A few mentioned they received no formal training in proper charting during university so when they entered the work force they had to learn about accurate note-taking from other healthcare professionals. Producing poor notes can have serious legal ramifications as well, because a kinesiologist's notes can be subpoenaed by the courts for use during a legal case. Additionally, kinesiologists who have poor note taking skills can negatively affect patients. If a kinesiologist were to leave a clinic for another, the poor notes of patients they treated in the first clinic would be difficult to understand and would make it harder for therapists in the original clinic to accurately interpret the treatments and progress of those patients. The following participant responses discuss the relevance of charting or note-taking.

P3: And charting is a huge piece. Like writing care plans, writing reports. That's a huge piece of our work here and that was never taught to us in school.

P3: They would have no idea how to chart, yeah. You know, and I have just learned through querying things, but if you didn't have that initiative you would be lost. And then your notes, your progress notes would be wrong and you could get reprimanded for them.

P4: So I don't know in terms of even just note taking, how much that is conveyed in terms of the importance of note taking. Because if say you were at a clinic and you were to leave, go to another clinic. You had 30 some patients on your list that you were working with on a weekly basis. If you had crappy notes, who is suffering? The patient, because then that person who picks this up has no idea really what you were doing because they are not specific or detailed enough or the plan or program wasn't outlined all the time. And again that goes to professionalism or whether it is just experience at the same time is that recognizing that what you enter now could be read six years later. That type of scenario.

P6: It is also a legal requirement in that if they ever pull your notes and take them to court it is quite important to have. It's things like that. Although I have got to say I am not a fan of all occupational therapists, they do have really good courses that do go into note taking, writing a report and that. I have even taken course from different companies and that with respect to how to write a report, things you shouldn't say or things you can't say... or you know terminology. That I think is important as well. That would give kinesiologists a step up.

P8: Umm I can't say I have referenced back to it in my practice but it must have been in my self-assessment because things around how I am charting, my charting protocol that I follow I believe needed improvement so that is one of my self-improvement goals, in terms of what information to take the order that you put it down etc. would be very important if someone was going to come back and look

at what you did, what actions there were. So I have been working on that. So that definitely applies.

P9: I have had to go to court with one my reports and you know what goes into assessment reports or progress reports even, that information is helpful.

P11: They don't teach anything like that in university, anything practical, they didn't really cover too much on that, but I kind of picked it up with different positions I have done.

P11: I would definitely say my notes are better now than they were when I started. I wasn't nearly as detailed with my notes and sometimes not as diligent, but just over time you just kind of pick up on those things and realize that they're not just there for information for everybody else but for yourself as well, trying to be as detailed as you can so that you can remember, especially when you have a large patient load you need as much detail on that paper as you can so that you can read it and kind of look back to track your progress and how the patient is doing.

The responses that generated this theme suggest that proper training related to charting or note taking is crucial if kinesiologists are to have qualified skills in the workplace. Accurate note-taking of patient treatment and progress is essential from a legal perspective and as an important means of communication among colleagues and other health professionals. It is another layer to enhance the ethical and professional readiness of kinesiologists before and during their entry into the work force. Good charting protects the public and ensures health information is thorough and accurate. These are critically needed skills kinesiologists must learn and practice as regulated health professionals.

Theme Eleven: Awareness and Acceptability

The regulation of kinesiology as a health profession began in April 2013 and the participants in this study believed there was little or no awareness and acceptability of this development among the public and healthcare community. Furthermore, many of those who know about the new professional status of kinesiology still are not sure of what exactly kinesiologists are or what they do. Five of 11 participants were concerned about the lack of awareness and acknowledgement of the kinesiology as a regulated health profession. They thought that the professional standing of kinesiology should be actively promoted in different sectors of society. The following are their responses that refer to the awareness of kinesiology as a regulated health profession.

P1: Well, we're a little bit more respected now but still people aren't sure what we are.

P1: Hopefully people will know what kinesiology means.

P2: We're going to be fighting a battle probably over the next 10 years where you're just becoming another one of those regulated healthcare professions that people don't know a lot about.

P3: Yeah I think it is really misunderstood, what the role of a kinesiologist is, especially in this work environment here. And everybody doesn't really understand what everyone's role is yet. So maybe with our regulated status it will give us more support in doing more of the clinical type work that we should be doing.

P6: But I think if we get the training itself and the kins get the training and there is more awareness out there, I think it is better for the profession.

Associated with a lack of awareness is a lack of respect and acceptability among the public and the healthcare community. Participants felt that having little recognition of what kinesiology is and what kinesiologists do makes it harder for the professionals to properly utilize their skills and move out of that assistant role that was mentioned in the first theme above. Again as a new profession, it is difficult to quickly establish credibility among other practitioners and the public, which is why it will be a struggle for kinesiologists in the coming years to become accepted as equals among other regulated healthcare professionals. Eight of 11 participants had something to say regarding the credibility and acceptability of kinesiologists. Most of their comments had to do with acting more like regulated health professionals as well as being more recognized in what they can do as health practitioners. The following are their responses on these topics.

P1: And as the college builds up, we have to be really diligent in proving that we deserve to be that registered profession.

P1: No it is really pretty well the same as any other registered health professional. And that's what I think we have to be. If we want to be taken seriously, and we want to be taken seriously as registered health professionals, we have to act like them. We can't slack off in any of the areas.

P2: Well I think we touched on it, the clinical placements, I think that is of the utmost of importance to gaining any credence as a profession.

P4: – what it has done as well is that it has given it a bit of further credibility. So at the same time with further credibility come increased expectations.

P8: Umm I do think there is still growth. I think there is still lots of room in niches that we can fit into and become more recognized in in terms of the types of

therapy that we provide. I think our preventative piece is huge and I am really hoping that the ministry more and more starts to pull in what we can do proactively to prevent injury in the first place or the preventative diseases and that like diabetes and arthritic conditions, cardiac issues.

P11: I don't necessarily have individualized clientele. So that I have been kind of trying to get a little bit of change with now that there is more regulation to it and it is a little bit more recognized as its own health profession.

The preceding comments provide evidence for the belief among participants that kinesiology is still an under-appreciated profession in terms of what it has to offer the healthcare community. Just over a year old, the CKO operates like other regulated health profession but it does not have sufficient recognition in the public. As it gains public awareness and credibility, the role that kinesiologists play in society will become clearer and acceptable. Still, much more work promoting kinesiology must be carried out to achieve the needed clout and prestige of this relatively new regulated health profession.

The eleven themes identified and examined in this chapter illustrate, through participant responses, some issues, concerns and suggestions regarding the profession of kinesiology. Ethical and professional training and education, the CKO's practice standards, guidelines and its code of ethics, plus specific ethical concerns in the workplace were included in this narrative. These topics will be discussed in greater detail in the next chapter, along with limitations to the research conducted in this study, and considerations for future research investigations.

Chapter Five

Discussion and Conclusions

The identified themes presented in the previous chapter, together with the content of the review of literature chapter will be discussed in greater detail in this chapter as related to the central research questions of this study. I will also address the limitations of this work, possible directions for future research, and provide several concluding remarks regarding this investigation.

Limitations of this Study in Drawing Relevant Conclusions

The conclusions reached in this study, presented later in this chapter, were influenced by certain elements of the research design and methodology and I would like to address these factors. First are the merits of member checking. This tool was useful in that it provided participants a chance to review each respective transcript of the interview and omit, add or amend any data from the interview, or make any further comments regarding a topic we spoke about. I found that member checking provided me with clarification of certain terms and acronyms; however few content areas were actually revised. Despite the few changes that were received, ten of the 11 participants confirmed they carried out the member checking process. As a result, member checking was somewhat useful, but the original transcripts captured by and large the participant responses as obtained during the interviews.

Second, as a novice researcher, there were areas of my interviewing skills that improved as I conducted more interviews. During my first few interviews I was nervous and uncomfortable, because it was something for which I had only limited practice prior to the study. Not until a few interviews later was I able to relax and begin to get

comfortable conducting interviews and speaking with practicing kinesiologists. The problem that this posed for me was that my probing skills at first were not as consistent or thorough as I would have liked them to be. By this I mean that when I asked a question and received an answer, sometimes, I would have difficulty producing probing questions to elicit robust responses from the participant. This skill improved as the interviews progressed and I began to gain more knowledge regarding ethical and professional issues kinesiologists encountered in the workplace.

Another limitation regarding the collection of interview data was the use of leading questions. Part of my methodology required me to try and stay as objective as possible, leaving my own interpretation and influence out of the interviews. I believe I succeeded in this to some degree, yet while transcribing the interview data, I noticed that I sometimes asked participants leading questions. This occurred more so later on in an interview session because I would ask a participant about something that a previous participant had mentioned. For example, I recall saying “other participants felt that the jurisprudence e-learning module was long and somewhat redundant, what are your thoughts regarding the jurisprudence?” Fortunately, I believe that the majority of the leading questions I posed did not influence the participants’ answers too badly because some did not agree with that assessment and had their own thoughts on the subject. In this way, I still felt that participants were providing independent perceptions on ethical and professional matters even though they were occasionally asked leading questions.

Finally, time was a major limitation to my study. An extensive amount of work was devoted to transcribing and coding the interview data. Due to the fact these tasks were part of an interpretive, selective process, I could not be entirely certain my

abstractions were the most accurate and prominent because I was uncertain of my ability to produce quality themes. It was also difficult at times to coordinate interview dates with participants because most of them worked full-time and had families to take care of after work. This made it difficult, especially for me, to be confident that the number of participants I interviewed was sufficient to collect enough relevant data. Overall I was satisfied with the 11 participants whom I interviewed, but there were several times when I contacted kinesiologists and arranged interview dates and times only to have them rebook or drop out of the study. This, of course, was frustrating because I would have kinesiologists commit to the study via telephone, only to have them not respond to my emails. This led me to assume that they were no longer interested in participating. Perhaps in an ideal world it would have been better to have collected data from 20 participants and uncover more thoughts and perceptions, however, the limitations of time, money and my being a novice researcher made such a number impractical. Furthermore, among the local kinesiologists I contacted many were not interested or unavailable to participate and I had to recruit kinesiologists from other regions. In this sense, I was fortunate to have recruited 11 participants while knowing this number is a limitation.

Research Question One: Changes to Ethical and Professional Education and Training

The healthcare environment is constantly changing and thus practitioners must undergo ongoing and regular training to keep up to date with their practice (Caldwell, Coleman, Copp, Bell & Ghazi, 2007). Currently active kinesiologists, like any other regulated health profession, are required to constantly partake in continuing education to keep pace with new knowledge and practices in their healthcare field (Regulated Health Professions Act, 1991, schedule 2, 80.1). Continuing education is put into place to ensure

that healthcare professionals remain competent and that they consistently improve the quality of their service. However, the prevailing view among kinesiologists interviewed in this study is that there is a lack of resources or relevant courses available for continuing education. Right now is a time where much is changing in the field of kinesiology which is why continuing education is probably most important. For example, kinesiologists can now own their own practice and treat patients referred to them from physiotherapists. One participant mentioned that it would be beneficial if the CKO provided the training so that kinesiologists could get a better understanding of what the College expects from them in terms of their practice. Having a course on what their new role and responsibilities as kinesiologists would provide clarification and confidence for those still unsure of the parameters of the scope of practice. Such instruction would also assist those who work in specialized areas, like the Workers Safety Insurance Board (WSIB), insurance companies and private practice.

Kinesiologists are looking for guidance from their provincial governing body, the College of Kinesiologists of Ontario (CKO), as well as their advocacy groups, like the Ontario Kinesiology Association (OKA) and the Canadian Kinesiology Alliance (CKA), to provide the necessary training, or at least the necessary resources and access to training so that they can further develop their skills and knowledge as a practicing, regulated health professionals. Furthermore, participants mentioned having training workshops and courses available outside of the Greater Toronto Area (GTA) would be beneficial. The CKO as well as the OKA and CKA may find such requests to be impractical at the moment, but as more and more people become registered and the profession grows they

may want to reconsider addressing the issue of lack of accessibility that some kinesiologists experience when trying to participate in continuing education courses.

More pressing issues, besides continuing education, are those that relate to the formal university education kinesiologists must successfully complete before becoming registered with the CKO and entering the workplace. At the moment, kinesiologists in Ontario must complete a four-year undergraduate kinesiology degree to acquire the relevant knowledge and competencies in order to practice. Now that the profession of kinesiology is regulated, the question arises as to how effective the university degree programs are in providing the appropriate education.

The biggest issue participants in this investigation addressed, referred to the lack of clinical placements. Many of them believed strongly that in order to be seen as a respected, legitimate healthcare profession, there needs to be a practical component within all kinesiology university programs in Ontario. They mentioned that all health profession programs, like nursing and physiotherapy, have required practical fieldwork experience yet kinesiology has not made this component mandatory. Clinical placements are seen as a necessity for the development of future kinesiologists and therefore should be one of the first things addressed by university kinesiology departments when amending the curricula. Once this needed dimension is in place, another issue is finding registered kinesiologists to supervise students and who can provide them with practical training as one participant stated that it will take some time until there are mentors in place to train kinesiology students.

Once again, as the profession proliferates there will be more registered kinesiologists working in Ontario, making the implementation of clinical placements

viable. Under the current circumstances, kinesiology students must find their own clinical experiences as volunteers or employees in various workplace settings under practicing kinesiologists and/or physiotherapists. However, while still in university many students are unaware just how critical hands-on experience is to become employed as a registered kinesiologist to actually observe and learn from ethics in action.

Therefore having that background in clinical education is extremely important for applying one's knowledge to the practice of kinesiology. As a recent kinesiology graduate student, I can attest to the validity of this previous statement. I was fortunate to have been one of about 20 students among my peers who acquired clinical experience, and because most of my friends graduated with no hands-on experience, few had any knowledge of what they could do as a kinesiologist once they finished school.

Another aspect of education that participants believed was very important but lacking in university degree programs was the skills to write accurate reports and progress notes. Kinesiologists, along with other healthcare professionals, can be required to submit their charts and notes to ethics boards and the courts as evidence when crucial ethical decisions are considered and legal action is taken. Therefore while it is important to have organized and detailed notes, there is no training in these areas in undergraduate programs. Furthermore, kinesiologists can receive low scores or be reprimanded for not having good notes when undergoing employee evaluations, which can negatively influence their license as a registered kinesiologist. Participants in this study believed that proper charting and note taking should be required components of the undergraduate degree program so that students have this knowledge and can effectively carry it out once they begin to practice.

The kinesiologists I interviewed also felt that there was a lack of ethical and professional training in university undergraduate kinesiology programs. These elements of the degree program are essential not only as preparation for the entry to practice examination when seeking to become a registered kinesiologist, but they are needed to practice safely and competently in the workplace. Participants felt that even though some undergraduate programs have already implemented ethics and professionalism courses into the kinesiology program, there still needs to be more consistent courses in all programs. Furthermore, such courses could also introduce students to the policies, rules and regulations of the CKO and give them more information about their responsibilities and what is expected of them once they are registered. Many of the participants in this study never received any formal ethical and/or professional training in their undergraduate degree programs and therefore they wished to see future students acquire this knowledge while in university.

A solution proposed by several participants that would help resolve some of these issues is to standardize kinesiology programs across Ontario. Having standardized programs would establish a stable set of required courses for undergraduate students and would prepare them sufficiently if they decided to become registered kinesiologists once they graduated. This would allow for students to follow a specific educational stream that would guide them toward becoming kinesiologists. Also, having a standardized program would make it easier for the CKO to further develop and/or adjust their entry to practice examination. Currently there are several different courses and programs that students take from different universities that make it easier for some and harder for others to do well on the examination. For example, one participant mentioned that there really wasn't

anything she learned in university on the exam. She also stated that because of the smaller size of her university, she did not have some of the resources that other students had from larger universities. Some participants in this study held the perception that confusion and lack of knowledge existed among current kinesiology students because they were unfamiliar with the CKO and its guidelines for becoming a registered kinesiologist.

Having the knowledge and understanding of what kinesiology is and where students can pursue their career are important aspects that should be implemented early on in their university degree programs. This way they can make informed choices when it comes to what they want to do when they graduate. Obtaining ethical and professional training only in their fourth year, as in some degree programs, makes it difficult for students to adjust their degree to focus on becoming a registered kinesiologist, or to get that volunteer experience throughout the summers after first, second and third years. If practical field work experience becomes required, as it should be, perhaps these parts of the curriculum would be offered earlier. It is often thought that educating the public about kinesiology is the most important thing for developing the profession, but in reality it is the education university students receive that is most critical for the profession to grow and prosper.

It is important students get the proper development because now kinesiologists are full partners within the healthcare system in Ontario and that is why the CKO is in place. In order to practice as a kinesiologist one must become registered with the CKO. As a bona fide profession, more expertise and skill supplements the multidisciplinary healthcare landscape in Ontario, especially in the areas of long-term healthcare and

chronic disease management (Braniff, Montelpare & McPherson, 2012). Not only can kinesiologists work with the sick and injured, but they can also work in preventative health, to ensure their patients lead healthy lifestyles. Alongside academic research, a thorough process over several years took place where much thought and evidence was considered before kinesiology became a new regulated healthcare profession. Today, kinesiologists fit into many different roles and have several different uses to the public. However, in order for kinesiology to reach its full potential as a health profession, it must be accepted by the public and other healthcare professions on an equal footing, proving that they are a benefit to the health of Ontario citizens and the Ontario healthcare system.

When the topic of professionalism was brought up with participants, they interpreted it as their profession's image and how they are viewed by the public. They believe that professionalism is an issue as it pertains to the lack of respect they receive from the healthcare community. Being a regulated kinesiologist means that they are health professionals, and yet they do not feel as though the public and the healthcare community view them as such. They are confident in their ability to practice as professionals, yet they believe that others do not perceive them as professionals. Therefore kinesiologists believe that their level of professionalism is undervalued and that the public along with the healthcare community do not think they have the skills and training to be healthcare professionals. Being given sufficient recognition and appreciation for one's specialized skills and services in the workplace are areas that participants in this study felt were not forthcoming. Kinesiologists were still being grouped together with physiotherapy assistants and occupational therapy assistants even though their education level and expertise were much higher. The knowledge and skills

kinesiologists possess grant them more duties and responsibilities, yet many perceive them to be assistants to more established healthcare professions.

Now that kinesiology is regulated and there are clearer guidelines regarding what kinesiologists can do and how they enhance and improve the healthcare system, there needs to be greater progress among health organizations, companies and private clinics to hire kinesiologists as independent practitioners. Kinesiologists need to continually show they deserve to be regulated, but the healthcare community must give them the opportunity to prove they are highly educated and skilled beyond the assistant role.

This complaint raised another issue that kinesiologists in this study perceived as a relatively new regulated profession, and that is awareness. Participants felt that the level of awareness and knowledge of kinesiology among health professionals and the public is extremely low, and that there needs to be more promotion and exposure related to who kinesiologists are and what they can do.

Participants I interviewed understood that as a new regulated healthcare profession there are lots of things the public will not know about them, and greater awareness and recognition will take time. This was the consensus among most of the kinesiologists who were interviewed. Based on their workplace experience, the majority agreed that the profession has not yet achieved the legitimacy and level of respect they are seeking. Educating the public and other healthcare professions will be an uphill battle and there should be local and broader strategies for informing these sectors of society as to the distinctiveness and relevance of kinesiology practitioners. The participants here believed the profession will continue to flourish in the future and were optimistic that kinesiologists will be perceived as equal to other healthcare professionals. For now,

education, promotion and exposure will convince others of the benefits of kinesiology toward improving the healthcare delivery system in general.

There is still much for kinesiologists, their governing body, and their advocacy groups to do in terms of establishing kinesiology among other healthcare professions and educating the public. Kinesiologists want to be recognized by the healthcare community for what they can do, and no longer wish to be under-valued and placed among PTAs and OTAs. I am not here to diminish the work of PTAs and OTAs as they provide a valuable service to the healthcare community in reducing the work load and freeing up more time for physiotherapists to provide care to more clients, but the level of skill and knowledge that kinesiologists possess should elevate their role beyond that of PTAs or OTAs because kinesiologists have the skills to work independently, managing their own patient load. Furthermore, once kinesiologists have been recognized for the work they can do, they will gain much more respect from their fellow practitioners and public awareness will increase. There will be a time when kinesiologists across Ontario will all be receiving referrals from physiotherapists and chiropractors as independent practitioners and will be running clinics of their own. This is when the profession of kinesiology will have achieved complete legitimacy and be fully accepted by the public and other healthcare professionals.

It is clear within the CKO's standards and guidelines that more elaboration is needed when addressing clinical placements and internships. The qualitative document analysis (QDA) conducted in the review of literature chapter revealed that the standard on clinical placements was insufficient. For example, there needs to be more information on how to encourage kinesiologists to take on student interns and to teach future

kinesiologists not only technical skills but also ethical and professional practice in the workplace. While such clinical experiences do not always teach best practices, students would learn about the practical implementation of skills and observe ethics and professionalism in action. Furthermore, the CKO's regulatory documents should perhaps be revised to educate the public about the duties and responsibilities of kinesiologists. If such documents were improved it would increase transparency and the public would have a clearer idea about the type of care they should expect from practicing kinesiologists.

Research Question Two and Three: Knowledge and Use of the CKO's Regulatory Documents

As stated in the introduction of this thesis, becoming a regulated health profession means that kinesiologists must assume ultimate responsibility to act ethically and professionally and practice with the highest standards of integrity to ensure the safety of the public. No longer does performance and competency of kinesiologists reflect the healthcare practitioner they are working for, such as physiotherapists. With this increased power and independence comes greater responsibility to provide safe and ethical care to the public and by extension kinesiologists must become more aware of and apply the rules and regulations their governing body, the CKO, mandates them to follow.

Becoming familiar with the CKO's practice standards, guidelines and its code of ethics by merely taking its required online jurisprudence e-learning module in a short amount of time may not be an effective method for ensuring that kinesiologists fully understand their professional responsibilities and how to put them in practice. Doane and colleagues (2009) reported that nurses who tried to understand and apply regulatory and ethical documentation on their own found such information confusing and misleading. This

situation would often lead to neglecting these guidelines altogether when confronted with ethical issues. This, of course, is not the approach used by the CKO. The jurisprudence e-learning module that kinesiologists must complete provides a minimum understanding of legal and ethical topics that regulate their practice. As the CKO states, “All applicants are required to demonstrate familiarity with the laws, regulations and standards that relate to the practice of kinesiology in Ontario by completing the jurisprudence e-learning module” (College of Kinesiologists of Ontario, Registration, 2013). While some kinesiologists interviewed in this study found this e-learning exercise to be redundant and mostly common sense, others saw it as a necessary refresher and even a few people mentioned that it was their only source of ethical knowledge and training, other than what they picked up on the job.

Participants who viewed the jurisprudence e-learning module to be redundant all had many years of experience and therefore much of their knowledge of professional and ethical conduct was gained through their work experience. Having only one participant who wrote the CKO’s entry examination meant that the majority of participants had enough work experience to be grandfathered in as members of the CKO. When looking at the overall picture of the importance of the jurisprudence e-learning module one can see that only for the first few years will there be this inconvenience among those being grandfathered in, and from then on the majority of all those taking the jurisprudence e-learning module will be inexperienced students just finishing their kinesiology degrees.

Providing minimum basic training to comprehend and apply regulatory professional and ethical guidelines is one way to ensure CKO members are aware of their responsibilities as health professionals, but is this approach sufficient? It is likely that

some of this knowledge may fade over time if the content of such documentation is not used in everyday practice. Many of the interviewed kinesiologists in this study stated that they do not refer to the relevant CKO websites and links on professional conduct very often or not at all. This does not mean that the identification and resolution of any ethical issues cannot be addressed reasonably through workplace experience. However, if the majority of kinesiologists do not refer to the CKO's practice standards, guidelines and its code of ethics regularly, then why are these documents significant at all, and perhaps the online jurisprudence tutorial is not needed?

According to the kinesiologists in this investigation, the CKO's professional standards and guidelines are significant but as resource tools in case unusual or exceptional professional and ethical situations arise where they are unsure of what to do. This limited and selective use of relevant CKO documentation not only provides practical usefulness in being a responsible practitioner but it also helps establish kinesiology as a more respected and recognized profession. The interviewed participants believed that even if the CKO documents are not consulted very often, the information still provides a needed foundation for the professional practice of kinesiology in order to elevate its status and legitimacy in relation to other regulated health professions in Ontario.

Kinesiologists interviewed in this study also commented on the quality of the CKO's practice standards, guidelines and code of ethics. Producing and implementing regulatory documentation are important provided these resources are accurate, reasonable and comprehensible. Participants I spoke to perceived that much of this information as being quite general or vague. They mentioned that since kinesiologists work in many different sites in the healthcare system, a general knowledge of professional conduct as established

by the CKO has limited specific benefits. Therefore more information and guidance was needed to address ethical issues and situations in particular workplace settings.

Participants continued by saying that much of the focus is placed on clinical, rehabilitative sites and they wanted more information related to circumstances like cancer and disability management.

A certain degree of specificity in terms of professional standards and guidance would go a long way to reaching out to and resonating with more practicing kinesiologists who find themselves in diverse workplace circumstances. This would make it much easier for kinesiologists who work in specialized areas to have practice standards and guidelines more specific to their respective jobs. In terms of the comprehensibility of the regulatory documentation, kinesiologists I conversed with found the information to be relatively easy to understand but there was still room for improvement. They wanted the accessibility of the documentation be made more convenient because at the moment it was difficult to sort through and find particular pieces of information when trying to resolve an ethical problem. For example, one participant recently had a consultant perform an assessment with a client. The client wanted to tape record the assessment, but the practitioners were unsure whether or not this was allowed. They searched the consultant's standards and guidelines only to find no information regarding the issue; therefore there was no available information to guide the consultant and the kinesiologist to make an informed decision. Although guidance for this situation was also unavailable within the CKO's practice standards, guidelines and code of ethics, this lack of information may not be a reflection of the efforts of the CKO but on the legislation that informs the CKO of what to include in its regulatory documentation.

As already mentioned, very few kinesiologists in this study regularly checked the CKO's practice standards, guidelines and its code of ethics and relied on their job experience to deal with ethical situations in the workplace. New kinesiology graduates with little practical experience will likely refer to the CKO's documentation for guidance more often to ensure they conduct themselves professionally and with integrity. Even though an older generation of kinesiologists find the CKO documentation less useful on a day-to-day basis, they still recognize the importance of professional standards to establish kinesiology as a respected, bona fide health profession in Ontario. Finally, legal and ethical issues are addressed by the required jurisprudence e-learning module that all CKO members must successfully complete to ensure that a minimum foundational level of understanding of professional conduct matters is familiar to all kinesiologists. Whether or not this type of learning is sufficient can be debated. So far the CKO considers this level of training sufficient to protect the public from harm and to make clear the professional and ethical responsibilities of kinesiologists.

There are some key points from within the QDA of the CKO's regulatory documents that touch on the issues discussed above. When utilizing the standards, guidelines and code of ethics there will be a gap between experienced and inexperienced kinesiologists. Those who have practiced for years will continue to use their work experience to guide their ethical and professional decision making, whereas those who are new graduates will refer more to the regulatory documents. Bridging that gap will be difficult and it will be interesting to see if those who do utilize the regulatory documents now continue to use them when they see themselves as experienced kinesiologists. Also, the usefulness of the regulatory documents can be related to who the documents are

designed for. Kinesiologists who do not work in therapeutic settings or who work in specialized areas not mentioned in the regulatory documents will likely have little reason to refer to them. The importance of encapsulating all areas that kinesiologists work in is to provide proper guidance to all, and not just to most. When looking at whether or not these regulatory documents do provide guidance, it is important to refer to Pattison (2001) who states that if regulatory documents are difficult to understand, there is the potential for them to be completely ignored. However, from the QDA in this study I found the documents to be presented and organized reasonably well and they do provide adequate guidance when used. I believe there are areas within the CKO's standards, guidelines and code of ethics that require revision and improvement, and perhaps sharing the findings and conclusions of this study with the CKO will lead to such changes.

Research Question Four: Dealing with Specific Ethical Issues

This section will start off by focusing on ethical issues kinesiologists interviewed in this study have recognized and faced in the workplace. Some are major issues and others are typically viewed as minor because they occur on a more regular basis. Also, if the information was provided by the participants, I will mention how they resolved these ethical situations.

First we will discuss some of the major issues the kinesiologists here brought up. The first circumstance concerns professional boundaries. A participant mentioned that a patient tried to become romantically attached to her. This made the kinesiologist uneasy and she was unsure how to deal with a situation which she had never faced before. Eventually she referred the client to another therapist and severed the potential relationship before it went too far.

The kinesiologist had to refer the client to another practitioner as the professional relationship had broken down between the two and it is unclear whether or not the kinesiologist referred to her governing body's standards and guidelines when dealing with this ethical issue. If she had, she would have found an ample amount of information on how to properly deal with this patient within the CKO's practice standards and guidelines. First, the standard on professional boundaries details the type of relationship that should exist and how to maintain it. There is a clear definition of the relationship and the standard provides suggestions for how to ensure the professional boundaries are not crossed. If the standard was unable to provide the adequate information to the kinesiologists, the guideline on therapeutic relationships would have surely done so. This guideline is very thorough, providing an even more detailed description of professional boundaries, how not to cross them, and what to do if a patient tries to cross them. The guideline states that reiterating to the patient in a sensitive manner what the therapeutic client relationship is and the importance of maintaining it is the first step. It further states that having another colleague or practitioner present when working with that specific patient is also a good idea.

The only aspect of the CKO's guideline and standard on professional boundaries and the therapeutic client relationship in which it falls short is that there is no information on what to do if the patient is still continuously breaching that professional boundary. However, if you move to the standard on discharging a client, there is information regarding reasons for discharging a client. In this section, kinesiologists are given some examples when it is justifiable to refer a patient to another practitioner. The only recommendation I would make is to have within the standard and guideline on

professional boundaries and therapeutic client relationships is a referral section to discharging a client when the client is continuously breaching professional boundaries.

Another kinesiologist had a professional boundary issue where she had a patient ask for her number. The participant clearly stated to the patient that it is against their policy to date patients and that it would be unprofessional. This participant did not feel it was necessary to discharge the client, and this is a discretionary decision that kinesiologists must make. She did exactly as the standards and guidelines of the CKO instructed, which was to inform the patient that it is unprofessional to date patients and that it is against her work's policy. These two participants are clear examples of why the CKO's standards and guidelines are important to the profession in terms of protecting kinesiologists and developing trust with the public.

Another major issue occurred when a patient appeared to be intoxicated during a treatment session. The patient's inebriated state was confirmed when the patient stated he was drunk and could not perform some of the treatment activities. The kinesiologist recorded the episode as it unfolded in the patient's chart. The patient challenged the report and claimed he was not drunk and filed a complaint with the kinesiologist's governing body. The kinesiologist was reassured by the governing body that she did the right thing and indicated that perhaps the wording in the report could have been better stated.

The final major ethical issue that a kinesiologist mentioned was regarding a functional assessment evaluation (FAE). The kinesiologist was facilitating an FAE that another practitioner was conducting, and when the patient arrived, they wanted to tape record their assessment. Unsure of whether or not this was allowed, the kinesiologist and

the other practitioner began checking in the practitioner's regulatory documents for the answer. Unfortunately they were unable to find the information they were looking for. The kinesiologist did not explain how this matter was resolved and stated that they were also unable to find any information pertaining to this issue within the CKO's practice standards and guidelines. This episode shows that there is still some information that the CKO should add to its practice standards and guidelines.

The issues above are ones that do not occur often in the workplace. However uncommon, this proves that ethical issues like these do arise. Therefore as stated within the earlier QDA, it would be beneficial to include real workplace examples within the CKO's regulatory documents. Not only would examples help kinesiologists better prepare for these types of situations, but more importantly, it would help them avoid these situations all together.

We will now discuss other matters that several kinesiologists in this study reported as occurring fairly often that also relate to professional boundaries. Kinesiologists found that when providing care to patients, the patients would often want to talk to them about personal things and wanted to get to know their therapists more intimately. Kinesiologist found that there were some personal topics they could discuss with patients and still maintain a professional relationship, but more often than not patients became too comfortable and crossed that professional line. This can compromise the professional interaction between patients and kinesiologists and it is sometimes difficult to draw the appropriate professional line. The common solution some suggested in this study was to simply avoid personal topics with patients and focus on the therapy at hand.

On a similar note, another common issue is that patients enjoyed talking about and learning about other patients within the clinic, especially during group therapy sessions. This of course raises a confidentiality matter as everyone is entitled to privacy. Practitioners are required, by law, to maintain the confidentiality and privacy of the patient and to not discuss private matters with anyone who does not have authorization. In such circumstances, the common response kinesiologists provided was to state something like, “unfortunately I cannot discuss other patients or disclose any information regarding them.” One must also say this in way that does not offend patients who may be innocently curious and do not even realize they are prying into the private affairs of other patients. Still, there may be times when no matter what kinesiologists do, inquisitive patients will become upset. One participant in this study stated that she had a patient ask for other patients’ phone numbers. Informing that patient that she was not allowed to give out other patients’ personal information, the patient then approached the receptionist for the information. Still unable to obtain the phone numbers the patient became upset. The kinesiologist informed the patient that if she wanted the information she was going to have to ask the other patients for their phone numbers.

Staying on the topic of information sharing, several kinesiologists in this study talked about the issue of patient honesty. Often patients do not completely disclose their injuries or they over emphasize their injuries in order to adjust and maximize their benefits. This makes it difficult for kinesiologists to identify the extent of injuries or health problems, conduct proper evaluations, and prescribe effective rehabilitative exercise programs or some other treatment. Therefore there were ways to check, through the use of hands-on tests and observation, to see if patients were telling the truth. If

kinesiologists did not believe patients were being honest then they tried to educate patients about their injury and tell them politely how being less than truthful could cause further damage. These were techniques to persuade them to be more honest.

Once again it is important to emphasize how useful examples would be to practicing kinesiologists, especially with common ethical issues like the ones listed above. Providing concrete accounts of ethical issues and how to properly deal with them is a major criticism revealed by the QDA. The regulatory documents provide a substantial amount of information, yet that information would have more practical value if there were examples of ethical issues in the workplace, as well as examples of how to use the CKO's standards, guidelines and code of ethics. For example, the code of ethics provides a step-by-step decision making model, yet kinesiologists in this study were not formally trained on how to use that model. Refined moral reasoning skills are needed when examining a difficult ethical problem. A detailed explanation and tangible examples on how to use the step-by-step decision making model to resolve serious ethical problems would go a long way in improving the CKO's code of ethics, as well as possibly increase its use. The ideas of usefulness and comprehensiveness are central to this criticism. If kinesiologists cannot understand and/or properly use the code of ethics there is greater likelihood it will be ignored.

These are some major and minor ethical and professional issues that kinesiologists face within the workplace. Most kinesiologists identify their work experience as the main method of resolving these issues, yet some mention referring to the CKO's regulatory documents. Although some of these issues may not occur often, it is still important to understand them and learn from them as it is likely that another kinesiologist may

experience a similar ethical problem. There will also be ethical and professional issues in the workplace that are new to kinesiologists and there may be few resources that can help them deal with these issues effectively. For the most part, the participants in this investigation felt that they could identify and resolve ethical problems in the workplace reasonably and effectively. This may not be the case for all kinesiologists and therefore these and other ethical and professional matters must be explicitly addressed within the CKO's practice standards, guidelines and code of ethics, if they are to be reliable resources.

Future Research

Kinesiology is one of the newest regulated health professions in Ontario and there is virtually no established research on the profession itself in its present state. Therefore, suggestions for future research are definitely in order. First, this study focused on the perceptions of ethics and professionalism among practicing kinesiologists without regard to specialized workplace areas. Future research therefore should investigate these perceptions in specialized areas because as kinesiology expands, more kinesiologists will be working in specific settings within the healthcare system and will be faced with more particular ethical and professional concerns.

Research should also be conducted with university kinesiology students to know how familiar they are with kinesiology as a profession, the policies, rules and regulations of the CKO, and advocacy groups like the OKA and CKA. It is important to find out how much students know about the practice of kinesiology and what it means to be a registered kinesiologist. As a graduate teaching assistant, I can say that many undergraduate kinesiology students were unaware of kinesiology as a regulated

healthcare profession or how to become a kinesiology professional. Along with this research, studies should also address the curriculum currently being used by university kinesiology programs and the merits of creating a standardized curriculum for all Ontario universities. Included in such investigations should be an assessment of the need for clinical internships that can provide students with necessary hands-on experience and adequately prepare them for work after university.

Finally, I believe that as the healthcare system in Ontario becomes more focused on collaborative health teams among various professions, research should be conducted that examines the impact of kinesiologists within these collaborative teams. There must be concrete evidence to support the claim that regulated kinesiologists provide tangible benefits and that their services are assets within the healthcare system. In this way, kinesiology can be shown to be a legitimate and worthy healthcare profession that can stand on its own and make substantial contributions across the healthcare landscape.

Related to this research is the influence that the CKO and kinesiology's regulated status will have on other Canadian provinces and the world at large. By government edict, Ontario is leading the way in formally recognizing the profession of kinesiology and this development will likely have far reaching effects. Knowing the extent of this influence and how much attention it is receiving from other jurisdictions is worthy of examination. The present study is merely a stepping stone to help researchers generate ideas and formulate research projects of their own regarding ethical and professional conduct and the profession of kinesiology. There are numerous directions that such investigations can take to enhance the literature base of kinesiology as a regulated health profession.

Concluding Remarks

For the most part, practicing kinesiologists interviewed in this study are happy with their new regulated status because it provides independence and freedom within their practice. However, almost half felt they were perceived by the public and other professions as assistants to physiotherapists or occupational therapists. This is somewhat understandable because the profession is still in its infancy. One of the few studies that examined the impact of the regulation of kinesiology is one that surveyed a number of health professions in Ontario to get their reaction to the regulation of kinesiology (Braniff, Montelpare & McPherson, 2012). It was revealed that most allied health professions saw the regulation of kinesiology as a potential benefit to the healthcare system. However, they cautioned that kinesiologists must be able to clearly define who they are, promote their unique contributions, and demonstrate that they can establish excellence in delivering services within a clearly defined scope of practice (Braniff, Montelpare & McPherson, 2012).

In line with the preceding points, kinesiologists in this work believed in the regulation their profession, but they recognized there is much work that needs to be done in order for kinesiology to be viewed as equal to other well established health professions. Kinesiologists have the skills and knowledge to self-govern, but have yet to step completely into a fully recognized professional role. They will continue to struggle from under the shadow of other healthcare professions and acceptance by the public will take some time.

Currently, there is little evidence to counter the statement that kinesiologists are adequately trained and knowledgeable in the area of ethics and professionalism.

However, like other regulated health profession, kinesiologists are now striving to learn more and go above and beyond simply being satisfied with their knowledge and training. They know that if they want to be taken seriously as a regulated health profession that they need to begin acting like one, and that means participating more in continuing education and demonstrating how they can improve the health of Ontario citizens and contribute positively to Ontario's healthcare system. While kinesiologists may be satisfied with their level of ethical knowledge and training, many in this study wished to see improvement in these areas by suggesting kinesiology students enrol in required courses on ethics for practicing kinesiologists while in university and after graduation.

The fact that participants in this investigation rarely, if at all, consulted the CKO's practice standards, guidelines and code of ethics may be an indication that more education is required. Many interviewed in this study have worked under physiotherapists, chiropractors or other regulated health professionals where they gained a great deal of their ethical knowledge from the standards and guidelines of other health professions. This will be the case for the majority of registered kinesiologists who have been grandfathered as members of the CKO. However, the participants I interviewed believed that as the profession grows and kinesiologists begin working for themselves once they leave university, they will rely more on the CKO's regulatory documents. In other words, they will not be working under the regulations of another health profession, but will be working more independently and complement other health professions.

It is important therefore that kinesiologists get ethical and professional training and knowledge at the university level. This includes hands-on, clinical experience, as participants stated in this work, to enhance the skill level and competency of newly

regulated kinesiologists. Clinical experience in the practice of kinesiology must be required and fully incorporated within the university curriculum. This will ensure professional independence and kinesiologists will gain the necessary skills, knowledge and confidence to manage their own clients ethically and professionally.

Overall, the perceptions of registered, practicing kinesiologists regarding ethical conduct and professionalism, indicated that kinesiology is on the right path to becoming a legitimate, recognized health profession in Ontario. Kinesiologists in this study expressed their praise in some areas and concerns on other topics. The kinesiologists I spoke to were more or less happy with the structure and governance of the CKO, although they believed there was still room for improvement in some areas. Although they did not refer often to the CKO guidelines to resolve ethical issues or know more precisely standards of professional conduct, they wanted to be more engaged with the CKO. This finding was encouraging because it means that practicing kinesiologists want more ethics and professionalism education and they see themselves as needing this education to be effective and informed practitioners. It was also important for them to keep up to date with the ever-changing healthcare environment. Moreover, their thoughts on the education of kinesiology students were telling and they believed necessary curricular changes, like clinical experience, must be implemented to ensure students understand the meaning of and possess the requisite skills in kinesiology as a profession in the fullest sense. It will be interesting to see the direction kinesiology takes in the years to come and reflect on what the kinesiologists in this study had to say during its nascent years as a regulated profession.

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Appendix A

Interview Guide

“Thank you for meeting me and I really appreciate your taking time out of your schedule to talk with me today. Before we get started I would like give you a brief description of the study and tell you a little bit about myself. I will also describe an ethical situation so you understand what I mean by an ethical problem or concern. After that I will have you read, make sure you understand, and sign the consent form and then we can begin.”

“Also, please know that if at any time you feel uncomfortable about a question just say pass and we will move on to something else. And just remember that the purpose of my research is to understand your perspective and no one else’s, so please do not be worried about trying to say the right thing or what I would like to hear.”

Example of an Ethical Issue:

As a kinesiologist you specialize in ergonomics, and one day you are with a client. The client asks for nutritional advice. You are aware that this is within your scope of practice but you are not sure if you can provide valuable nutritional advice because you are not a nutritionist specialist. You have a general idea of what is good nutrition and you eat relatively healthy, but you do not know enough to give the client sound advice. How would you explain your uneasiness to the client and resolve this situation?

“Ok, let’s begin...”

Open-ended questions

1. Please describe your background in the area of kinesiology and how you got to where you are today.
2. Now that you are a registered kinesiologist with the CKO, how has this altered your understanding of the kinesiology profession and your practice of kinesiology?
3. Please tell me about any new concerns you have as a registered kinesiologist that you may not have had before becoming registered.
4. I was wondering if you could tell me about the training and knowledge you received regarding ethics and professionalism (courses, classes, online tutorials, reading, and work experience).
5. Please describe your level of ethical knowledge and training. How could this part of your education have been improved?
6. Please tell me about any conflicts you may have experienced when dealing with an ethical situation? If you could refer to a specific example that would be helpful.

7. How much do you know about the CKO's professional standards of conduct and its code of ethics?
8. Please explain how much or how little do the CKO's professional standards of conduct and its code of ethics influence your practice of kinesiology, especially when faced with an ethical situation.
9. What changes would you like to see in making the CKO's professional standards of conduct and its code of ethics more relevant to you as a registered kinesiologist?
10. Now that kinesiology is a regulated profession, what changes, if any would you like to see to the university programs?

Is there anything further you would like to comment on or talk about regarding professionalism and ethics as related to kinesiology before we conclude the interview?

Appendix B

Questionnaire

The Perceptions of Kinesiologists of Ethics and Professionalism as Established by the College of Kinesiologists

Name:

Date:

What is your gender?

(Male) or (Female)

For the following questions, please circle the answer that applies to you.

1) What is your age?

1. 18-25
2. 25-35
3. 35-45
4. 45-55
5. 55+

2) How long have you worked as a kinesiologist?

1. Less than a year
2. 1-2 years
3. 2-5 years
4. 5-10 years
5. 10+ years

3) How long have you been licensed with the College of Kinesiologists of Ontario?

1. Less than 2 months
2. 2-4 months
3. 4-6 months
4. 6-8 months
5. 8-12 months

4) What type of setting do you work in (i.e. hospital, rehab clinic, etc.)?

5) What is your highest level of Education?

1. High School Diploma
2. College Degree
3. Bachelor Degree
4. Master's Degree
5. Doctorate degree

Letter of Invitation

Date:

Title of Study: The Perceptions of Kinesiologists on Ethics and Professionalism as Established by the College of Kinesiologists of Ontario

Principal Investigator: Danny Rosenberg, Professor, Department of Kinesiology, Brock University

Student Principal Investigator: Chad Denyes, Student, Department of Health and Physical Education, Brock University.

I, Danny Rosenberg, Professor and principle investigator, from the Department of Kinesiology, Brock University, invite you to participate in a research project entitled The Perceptions of Kinesiologists of Ethics and Professionalism as Established by the College of Kinesiologists of Ontario.

The purpose of this research project is to learn about your; knowledge of ethics and professionalism, ethical training, and how you have deal with ethical dilemmas. Should you choose to participate, you will be asked to fill out a small questionnaire regarding demographic characteristics (ex. age, level of education, work experience). After the questionnaire you will participate in an interview with the student principle investigator. You will be asked a series of questions regarding the College of Kinesiologists of Ontario (CKO) and what type of ethical training they provide and how effective that training is. Also you will be asked about how you choose to resolve ethical dilemmas.

*In order to participate in the study you must have roughly 12 months of experience working as a kinesiologist and must currently be practicing kinesiology.

The expected duration of this study is from 45 minutes to one hour.

This research should benefit you by allowing you to develop a better understanding of how to better resolve ethical dilemmas. You would also get a better understanding of your own level of ethical knowledge and what you are capable of in terms of resolving ethical issues. Kinesiology based university programs in Ontario as well as organizations like the CKO and the Ontario Kinesiologists Association (OKA) would also benefit by developing a better understanding of what sorts of problem solving methods their kinesiologists use, the level of ethical knowledge and problem solving skills they have, as well as how effective the CKO's code of ethics are in helping kinesiologists in resolving ethical dilemmas.

There is chance that this study may cause you to feel emotional stress. Talking about ethical dilemmas that you have experienced may bring back memories of situations that upset you.

This Research is sponsored by Brock University.

If you have any pertinent questions about your rights as a research participant, please contact the Brock University Research Ethics Officer (905 688-5550 ext. 3035, reb@brocku.ca)

If you have any questions, please feel free to contact me (see below for contact information).

Thank you,

Danny Rosenberg, PhD
Associate Professor
905 688 5550 x4289;
drosenberg@brocku.ca

Chad Denyes
Student
cd08th@brocku.ca

This study has been reviewed and received ethics clearance through Brock University's Research Ethics Board 12-301

Appendix D

Informed Consent

Date:

Project Title: The Perceptions of Kinesiologists on Ethics and Professionalism as Established by the College of Kinesiologists of Ontario

Principal Investigator (PI): Danny Rosenberg
Department of Kinesiology
Brock University
905 688 5550 x4289; drosenberg@brocku.ca

Student Principle Investigator (SPI): Chad Denyes
Department of Health and Physical Education
Brock University
cd08th@brocku.ca

INVITATION

You are invited to participate in a study that involves research. The purpose of this study is to learn about your; knowledge of ethics and professionalism, ethical training, and how you deal with ethical situations.

WHAT'S INVOLVED

As a participant, you will be asked to fill out a small questionnaire regarding demographic characteristics (ex. age, level of education, work experience). After the questionnaire you will participate in an interview with the student principle investigator. With your permission I would like to use an audio recorder during the interview to ensure that all data is collected and accurately interpreted. You will be asked a series of questions regarding the College of Kinesiologists of Ontario (CKO) and what type of ethical training they provide and how effective that training is. Also you will be asked about how you have resolved ethical situations. Participation will take approximately from 45 minutes to one hour of your time. Roughly one week later, with your agreement, I would like to email you a copy of the interview after it has been transcribed into words from the audio recording so that you can review it and make comments on it. I would ask that you please make notes on a separate page and email them back to me. The purpose of this is to ensure that what you said and the SPI's interpretations of what you said are accurate.

POTENTIAL BENEFITS AND RISKS

Possible benefits of participation include developing a better understanding of how to resolve ethical issues. You would also get a better understanding of your own level of ethical knowledge and what you are capable of in terms of resolving ethical issues. There also may be risks associated with participation. This includes possible emotional distress from talking about previous ethical situations that you have faced.

CONFIDENTIALITY

The information you provide will be kept confidential. Your name will not appear in any thesis or report resulting from this study; however, with your permission, anonymous quotations may be used. Shortly after the interview has been completed, I will send you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish. Also, because of the possibility of other persons or colleagues identifying you through geological factors, no names of people, places, organizations, or any other potentially revealing information will be used in this study.

Data collected during this study will be stored within an encrypted file. Any notes taken during the interview will be typed out and then placed in the secure file. Once typed out, paper notes will be shredded. Audio recordings along with any data will be kept for six months after the study is completed, after which time the information will be disposed of in a secure way.

Access to this data will be restricted to the student researcher (Chad Denyes) and the Faculty Supervisor/principle investigator (Danny Rosenberg).

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you wish, you may decline to answer any questions or participate in any component of the study. Further, you may decide to withdraw from this study at any time and may do so without any penalty. Should you choose to withdraw from the study any data collected with respect to you will be destroyed within a week. Information that is on paper will be shredded and any computer based data will be deleted.

PUBLICATION OF RESULTS

Results of this study may be published in professional journals and presented at conferences. Feedback about this study will be available via email with Chad Denyes at cd08th@brocku.ca. Feedback will be available roughly eight months after completing your interview.

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or require further information, please contact Chad Denyes or Danny Rosenberg using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University 12-301. If you have any comments or concerns about your rights as a research participant, please contact the Research Ethics Office at (905) 688-5550 Ext. 3035, reb@brocku.ca.

Thank you for your assistance in this project. Please keep a copy of this form for your records.

CONSENT FORM

I agree to participate in this study described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time.

Name: _____

Signature: _____ Date: _____

Appendix E

Telephone script

Hi, Could I please speak with _____. Hello, my name is Chad Denyes and I am a Master's student at Brock University. I am doing a research study regarding kinesiologists and was wondering if I could tell you a little bit about the study?

I am conducting interviews with working kinesiologists who are registered with the College of Kinesiologists of Ontario. The interviews will take approximately 45 minutes and the question I am asking will be regarding the College of Kinesiologists of Ontario (CKO) any ethical training they provided and how effective that training is. We will also talk about the College's professional standards and guidelines, what you think of them and your thoughts about ethics as a kinesiologist in general.

If this is something you may be interested in participating in I would love to send you an email with more information regarding the study?

(If yes)

Excellent, I will send an email and I look forward to hearing back from you.

(If no)

Ok, thank you very much for your time and have a great day.

Appendix F

Email Correspondence Guide

The Perceptions of Kinesiologists of Ethics and Professionalism as Established by the
College of Kinesiologists of Ontario

Hi,

My name is Chad Denyes and I am a Master's student at Brock University. I am conducting a research project with respect to ethics and professionalism in kinesiology. I am looking for kinesiologists to participate in my study. In order to participate you must have roughly 12 months of experience working as a kinesiologist and must currently be practicing kinesiology. The study takes approximately 45 minutes to one hour and consists of a small questionnaire and an interview.

Please read the attached letter of invitation if this may be of interest to you and pass it on to any other kinesiologists you think may be interested in participating.

If you are interested in participating feel free to email me to set a date and place that is convenient to you.

Thank you for your time and consideration,

Chad Denyes

Master's in Applied Health Science

Brock University

Appendix G

Definitions

Standards – The College of Kinesiologists of Ontario (CKO) defines this term as “a minimum set of features or characteristics that ensure quality” (CKO, 2013, p. 1).

Patient – A client for medical services (Merriam-Webster online dictionary)

Integrity – the quality of being honest and fair (Merriam-Webster online dictionary)

Well-being – The College of Nurses of Ontario (CNO) refers to a client’s well-being as “a means of facilitating the client’s health and welfare, and preventing or removing harm (CNO, 2009, p. 5).

Therapeutic relationship (nursing definition) – “The therapeutic relationship is established and maintained by the nurse through the nurse’s use of professional nursing knowledge, skill, and caring attitudes and behaviours to provide nursing services that contribute to the client’s health and well-being” (CNO, 2009, p. 3).

Controlled acts – “Activities that are considered to be potentially harmful if performed by unqualified persons” (CNO, 2011, p. 3).

For the purpose of my study, I am classifying an ethical dilemma/problem as more specific than an ethical issue. They pertain to a situation where one must choose between two or more alternatives in hopes of coming to a morally good decision. An ethical dilemma and an ethical problem will be considered interchangeable in the context of this thesis.

Furthermore, an ethical issue will be referred to as any problem or topic in the area of ethics. For instance, difficulty understanding a code of ethics could be an ethical

issue. Also, having conflicting thoughts when trying to make an ethical decision between two alternatives could also be an ethical issue.

Appendix H

Hippocratic Oath – Modern Version

Written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and used in many medical schools today.

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Appendix I



Practice Standard- Consent

Definitions

Consent: to acquiesce, agree, approve, assent and give permission to some act or purpose.

Informed consent: a phrase used in law to indicate that the consent given by a person has been based upon a clear appreciation and understanding of the facts, implications, and future consequences of an action. In order to give informed consent, the individual concerned must have adequate reasoning faculties and be in possession of all relevant facts at the time consent is given. In some instances, a substitute decision maker may be involved in giving informed consent.

Express Consent: consent that is given directly in explicit words, either verbally or written, by the patient/client or substitute decision maker, for a specific purpose.

Implied Consent: consent that is inferred from signs, actions, or facts or by inaction or silence. The standard that is applied to whether implied consent was obtained is based on whether a reasonable person in the same circumstances would believe that consent was given.

Intent

To facilitate appropriate assessment/examination or treatment of patient/client by ensuring that members comply with their obligations relating to consent.

Objectives

- To ensure that members and the public are aware of the mutual benefits of fully informed, voluntarily given consent to assessment/examination or treatment.
- To ensure members are aware of their existing obligations relating to consent.
- To clarify the consent requirements outlined in legislation, the case law, shared professional values and various existing College Practice Standards, policies and guidelines.
- To ensure patients/clients receive appropriate information about the nature, benefits, risks and side effects of kinesiology assessment/examinations or treatments.
- To facilitate discussion and dialogue between members and patients/clients relating to kinesiology care.

Description of Standard

Members must respect the autonomy of patients/clients and will only assess/examine or treat them with their informed consent with rare exceptions (e.g., an emergency).

Elements of Consent

Every member of the College must ensure that the patient/client or their substitute decision maker, including an authorized representative, consent to any assessment/examination or treatment or to a course of treatment that is:

1. fully informed;
2. voluntarily given;
3. related to the patient/client's condition and circumstances;
4. not obtained through fraud or misrepresentations; and
5. *where appropriate*, evidenced in a written form signed by the patient/client or otherwise documented in the patient/client record.

Consent can be written, verbal or implied. Implied consent (e.g., taking a verbal history from a patient/client) should be used with caution because it is easy for a misunderstanding to occur. For example, a patient who disrobes on request may not be consenting to all forms of touching (or, in some circumstances, any touching at all). Since it is the duty of the member to obtain informed consent, the onus is on the member to ensure that the patient/client understands and appreciates what is being asked and agrees to it.

Appropriate Discussion and Dialogue

In order to be "informed," consent to assessment/examination or treatment (including imaging), includes a discussion of the following:

1. What is the nature of the recommended assessment/examination or treatment?
2. Why should the patient/client have the assessment/examination or treatment?
3. What are the alternatives to the assessment/examination or treatment?
4. What are the effects, material risks and side effects of the proposed assessment/examination or treatment and alternative assessment/examinations or treatments?
5. What might happen if the patient/client chooses not have the assessment/examination or treatment?

In discussing the effects, material risks and side effects of the proposed assessment/examination or treatment and alternative assessment/examinations or treatments, members shall disclose improbable risks, particularly if the effects are serious. Accordingly, members shall include a discussion with patient/clients of the rare but potentially serious risk of pain or injury.

Obtaining consent is an ongoing and evolving process involving continuous discussions with a patient/client and not a single event of a patient's/client's signature on a consent form. If the member recommends a new assessment/examination or treatment, if there are significant changes in a patient's/client's condition, or if there are significant changes in the material risks to a patient/client, the member should continue the dialogue with the patient/client about the material risks, the benefits and side-effects of the recommended assessment/examination or treatment, including potential risks that may be of a special or unusual nature, and document those discussions in the patient's/client's chart.

During discussions, members should provide patient/clients with an opportunity to ask questions concerning the proposed assessment/examination or treatment and answer questions prior to the

commencement of the assessment/examination or treatment. Patients/clients may withdraw their consent to any assessment/examination or treatment at any time.

The standard of disclosure focuses on the patient/client and what a reasonable person in the patients'/clients' position would need to know to make an informed decision. Members are advised to err on the side of caution in providing comprehensive disclosure. In addition, if a patient has unique concerns (e.g., disrobing in front of a person from the opposite gender), this should be discussed as well.

Incapable Patients/Clients

Where a patient/client does not understand the information or appreciate the reasonably foreseeable consequences, he or she would be incapable of making the decision. Capacity can vary with the proposed intervention (e.g., the patient/client could be able to consent to an examination but not to a treatment plan) and over time (e.g., the patient/client has "good days and bad days").

Where the member concludes that the patient/client is not capable of consenting to a proposed intervention, the member is expected to inform the patient/client of this finding, where feasible, and include the patient/client in the process as much as possible. The member must then (absent an emergency) obtain consent from a substitute decision maker.

The *Health Care Consent Act, 1996* does not identify an age at which minors may exercise independent consent for health care because it is accepted that the capacity to exercise independent judgment for health care decisions varies according to the individual and the complexity of the decision at hand. Members are encouraged to seek consent from the appropriate substitute decision maker to treat children who do not have the capacity to consent to an assessment/examination or treatment.

The *Health Care Consent Act, 1996* sets out the priority of substitute decision makers and the principles that apply. The hierarchy of substitute decision makers is as follows:

1. The incapable person's guardian, if the guardian has authority to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.
3. The incapable person's representative appointed by the Consent and Capacity Board if the representative has authority to give or refuse consent to the treatment.
4. The incapable person's spouse or partner (which need not be a sexual partner).
5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This does not include a parent who has only a right of access and is not lawfully entitled to give or refuse consent to treatment. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, it gives consent.
6. A parent of the incapable person who has only a right of access.
7. A brother or sister of the incapable person.
8. Any other relative of the incapable person.
9. As a last resort, the Public Guardian and Trustee.

The substitute decision maker who is highest on the list makes the decision unless he or she is not willing or able to make the decision, is not capable themselves, or is not at least 16 years of age (unless that person is also the parent of the patient). If two equally ranked substitutes cannot agree

on a decision, then the Public Guardian and Trustee (a civil servant) makes the decision. For more information on the Public Guardian and Trustee, see:

<http://www.attorneygeneral.jus.gov.on.ca/english/>

The substitute decision maker acts as if he or she were the patient/client. The substitute decision maker is entitled to all of the information for making the decision just as the patient/client would be. The substitute decision maker is required to act in the patient's/client's best interests, taking into account any wishes expressed by the patient/client while he or she was capable.

Information Practices and Billing

The principles described above apply with some minor modifications to the collection, use and disclosure of personal health information (including patient/client records) and billing. Members will proceed only on the basis of full disclosure, patient/client choice and informed consent unless one of the recognized exceptions apply (e.g., disclosure of personal health information where permitted or required by law). See the Practice Standard on Record Keeping and the Practice Guideline on Privacy and Confidentiality for more information.

Legislation

Health Professions Procedural Code

Regulated Health Professions Act, 1991

The Professional Misconduct Regulation

The Health Care Consent Act, 1996

The Personal Health Information Protection Act, 2004.

Notation

In the event of any inconsistency between this standard and any legislation that governs the practice of members, the legislation governs.



Practice Guideline- Consent

Introduction

The ability to direct one's own health care needs and treatment is vital to an individual's personal dignity and autonomy. A key component of dignity and autonomy is choice. Regulated health professionals hold a position of trust and power with respect to their patients/clients and can often exercise influence over a patient/client; however, decision making power must always rest with the patient/client, or in the case of incapacity, the patient's/client's substitute decision maker (SDM). It is the right of every patient/client or their SDM to receive full and frank information on his/her condition, the options available and to provide free and informed consent to any matters relating to their health.

The issue of consent in the health care context is so crucial that Ontario passed the *Health Care Consent Act (HCCA)*, 1996 to ensure there is a legal framework on establishing, maintaining and recording valid consent that is consistent in all settings.

This Guideline serves as a further explanation to the College's Practice Standard on Consent with specific focus on the HCCA. While it focuses on the provisions of the HCCA, members should remember the principle of choice and consent and that obtaining valid consent at all times is the ideal. Where there are exceptions to the need to obtain consent, these exceptions should only be applied if absolutely necessary. Consent should always be sought before action takes place or as soon as possible thereafter. When assessing the need for consent or when seeking to obtain consent, a member should not look at the situation through a legal or technical lens; consent is a broad concept and ultimately involves the person's inherent right to choose and their right to dignity and autonomy.

The Health Care Consent Act (HCCA), 1996

The HCCA was passed in 1996 and it is multi-purpose in scope. It not only provides parameters on what, when and where consent should be obtained, but also establishes a framework for situations in which the patient/client is deemed incapacitated for the purposes of giving consent. In a broader sense, the act seeks to "promote communication and understanding between health practitioners and their patients or clients". By providing patients/clients with all of the necessary information regarding their condition and treatment options, a practitioner is including the patient/client in the process, thereby strengthening the efficacy of the therapeutic relationship and the autonomy of the patient/client.

When does the HCCA apply?

The HCCA outlines three major areas when consent is needed: 1) treatment; 2) admission to care facilities; and 3) the need for personal assistance services. Members will most often be operating under the treatment category. The scope of the HCCA does not negate the need for consent in other

matters such as disclosure of personal health information, which is dealt with under the *Personal Health and Information Privacy Act (PHIPA)*, 2004. The principles of the HCCA and the elements of consent outlined below should be followed in all situations where consent is needed, such as informing patients/clients about fees and billing.

Treatment

The HCCA defines treatment as "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan." The HCCA does provide a number of exceptions under the definition for treatment, which include, among others:

- (a) the assessment, for the purpose of this act, of a person's capacity with respect to a treatment,
- (b) the assessment or examination of a person to determine the general nature of the person's condition,
- (c) the taking of a person's health history,
- (d) the communication of an assessment,
- (e) treatment that in the circumstances poses little or no risk of harm to the person.

However, a prudent member may still wish to seek consent even when not required to do so under the HCCA. It should also be noted that taking a person's health history is considered collection of personal health information and therefore the need for consent under PHIPA would apply.

WHAT does consent look like under the HCCA?

The HCCA outlines the elements of consent to treatment as follows:

- 1. The consent must relate to the treatment.
- 2. The consent must be informed.
- 3. The consent must be given voluntarily.
- 4. The consent must not be obtained through misrepresentation or fraud.

1) The consent must relate to the treatment

Consent must be specific to the action the member proposes to take before the action takes place. This means that a member cannot obtain blanket consent for any and all assessments or treatments at the present time or in the future.

2) The consent must be informed

The HCCA defines informed consent as consent that is based on information which a reasonable person in the same circumstances as the patient/client would require in order to make a decision about the treatment. The HCCA specifies that the following matters must be discussed in order for the patient/client to provide informed consent:

- 1. The nature of the treatment.
- 2. The expected benefits of the treatment.
- 3. The material risks of the treatment.
- 4. The material side effects of the treatment.
- 5. Alternative courses of action.
- 6. The likely consequences of not having the treatment.

The Duty to Disclose

Informed consent is obtained by providing a patient/client or the SDM with full and frank disclosure of the items listed above, most notably the material risks and side effects of the proposed treatment. Providing this information is also often referred to as duty to disclose. The Supreme Court of Canada has held that the standard for disclosure is based on what information a reasonable person in the circumstances of the patient/client would require. The focus is on the patient/client.

Material risk

It is most often the potential risk(s), and/or the likelihood of the risk(s) occurring in relation to potential benefit(s) of a proposed treatment that is the deciding factor for a patient/client. A member should disclose all known risks or those that should be known of a proposed treatment. The latter requirement implies a duty on the member to be current with the state of science on the proposed treatment. Not all possible risks are material. However, if the risk is serious, or could result in permanent pain or injury, then the mere possibility of that risk may be material. The most notable example is risk of death. Even where death is only a remote possibility in a proposed treatment, its risk must always be disclosed. Another serious risk is the risk of a heart attack. A member who is assessing a person's cardiovascular performance, for example, should disclose the risk of a heart attack if it is at all present given the patient's/client's condition.

Members should use caution when providing prepared lists of risks. Common problems with lists are that they may not be exhaustive, they can become outdated and they may not be fully relevant to a particular patient/client. What may be a material risk to one patient/client may not be relevant to another. For example, a course of treatment that could result in pain or injury to a person's joint functioning may be more relevant to a high-functioning athlete than a person who does not engage in much exercise.

Care should also be taken with respect to explaining to the patient/client the consequences of foregoing treatment. The consequences or risks involved should be realistic and patient/client-based. The same principles involved in disclosing material risks should be applied to this situation. It is important that the member does not attempt to influence or sway the patient/client into accepting treatment by mentioning alarming but remotely possible risks, unless they are very serious. Having undue influence over a patient's/client's giving of consent, or being in a position of a conflict of interest, may invalidate the consent.

Communication

On-going dialogue and open communication between the patient/client or the SDM and the practitioner is essential for obtaining informed consent. Consent should be considered a process and not a single event. If the condition of the patient/client significantly changes or the member proposes a different treatment option, then consent should be obtained again. By the same token, members are encouraged to obtain consent to continue treatment where there has been no improvement in a patient's/client's condition. The member should always be realistic with the patient/client when it comes to discussing the likelihood of future improvement. A member may assess a person's condition as unlikely to improve but treatment is considered necessary to prevent regression and this should be fully explained to the patient/client before proceeding.

The HCCA does set out two situations in which consent can be presumed: 1) if there is a variation in the treatment, but the expected benefits, material risks and material side effects are not significantly different from the original treatment; or 2) if the setting in which the treatment takes place changes,

but there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting.

During discussions about the patient's/client's condition and treatment options, the member should provide opportunities for questions by the patient/client or the SDM. The member should seek to answer any questions when asked, if possible, or as soon as possible thereafter. If the discussion is lengthy and complex, the member should provide opportunities for questions throughout the conversation and should not always wait until the end of discussion to address questions. The patient/client may not be able to remember all of his/her questions if the discussion becomes complicated and prolonged.

Further, in ascertaining a patient's/client's circumstances in order to determine an appropriate treatment plan, the member will have to collect personal information, including personal health information, from the patient/client, which also requires consent under PHIPA. It is therefore important that when asking the patient/client questions that the member explains the purpose of the questioning and ensures the confidentiality of the information provided. For example, a member may want to ascertain what a patient's/client's family and financial situation is because this may affect their ability to take part in an expensive and time-consuming treatment program. Questions of this nature may at first seem irrelevant to a patient/client unless the member explains the purpose in relation to a proposed treatment.

Members must also be satisfied that the patient/client or the SDM understands the discussion about treatment. Every patient's/client's ability to comprehend health matters varies, and the member should be mindful of any indications that the patient/client does not understand what is being said and should adjust their communication accordingly. If there is a language barrier, the member should consider having a colleague, staff member or a family member of the patient/client assist with translation. The use of diagrams or written information may also be helpful. The member can also consider having the patient/client explain back to the member, in his/her own words, the nature of the treatment and risks and benefits involved.

The member must also allow the patient/client time to provide consent. The patient/client may need a few days to think about the options or obtain a second opinion. Where a treatment poses greater risks, the member should encourage the patient/client to seek a second opinion from a relevant health care practitioner.

Withdrawal

Consent may be withdrawn at any time and this withdrawal should be respected by the member immediately (provided the withdrawal is made by a capable patient/client or the SDM). Moreover, patients/clients should be informed of their right to withdraw consent at any time. The patient/client should be reminded of their right to withdraw consent every time consent is being sought.

Documentation

The signature of a patient/client or of the SDM on a consent form is not conclusive proof that the member obtained informed consent. This is true even if the consent form contains detailed information about the nature of the treatment and the risks involved. A signed consent form is only an indicator that a discussion surrounding consent took place.

In addition to any consent form, the member should make detailed notes in the patient's/client's records regarding the nature and content of the discussion around consent and follow all other documentation protocols and standards. In a situation where the member is relying on implied consent, the notes should be sufficient that a reasonable person could assume consent based on the circumstances outlined in the notes. Below is a discussion on implied consent.

Implied Consent vs. Express Consent

The HCCA allows for consent to treatment to be express or implied. Express consent is provided directly from the patient/client or SDM in explicit words or in writing. Therefore, express consent can be either verbal or written.

Implied consent is consent that is inferred from signs, actions, or facts or by inaction or silence. The standard that is applied to whether implied consent was obtained is based on whether a reasonable person in the same circumstances would believe that consent was given. An example of implied consent might be where a patient/client holds out their arm and tells the practitioner that they have pain in their wrist. This may imply that they consent to the practitioner looking at and touching their wrist.

Members should exercise great caution when relying on implied consent. Implied consent is subject to interpretation, which can lead to misunderstanding. Interpretation of someone else's actions may not take into account that person's religious or cultural customs, personal habits or behaviours or the inherent power imbalance between the member and the patient/client. For instance, a patient/client may have a nervous habit of nodding their head during a conversation, but this may not mean they are consenting to the proposed action of the member. Further, there are certain circumstances where implied consent should not be relied upon. The more serious an intervention or invasive a procedure being proposed is, the greater the need for express consent. Members should also be acquainted with the need for express consent with respect to the disclosure of personal health information in certain circumstances under PHIPA (see the College's Guideline on Privacy and Confidentiality of Personal Health Information).

3) The consent must be given voluntarily

Consent must also be voluntary, which means that it must be given free of undue influence or duress. As stated previously, members should be mindful of their own influence over the patient/client. Where the power imbalance is greater, the patient/client may want the member to make the decision or feel they have to accept the member's recommendation.

Members must also ensure that any other person, such as a family member or other representative, is not pressuring the patient/client. There may be situations where a patient/client relies on another person to help them understand the information that is being provided by the practitioner; however, this does not mean that the patient/client is unable to consent freely on his/her own behalf. Members should inform the patient/client that consent to treatment is their choice and that they should make it freely without any pressure from anyone else.

4) The consent must not be obtained through misrepresentation or fraud

In providing the information about the treatment to a patient/client, the member must be frank and honest. The member should not be in a conflict of interest when making recommendations. If the member is recommending any course of treatment or product where the member has a relationship with another provider, this should be disclosed and alternatives provided as well.

Where does the HCCA apply?

The HCCA applies to all settings in which a regulated health professional may be practicing, even if the setting is non-clinical in nature. As a regulated health professional, a member is expected to obtain consent for all treatment matters wherever they occur. A member who is providing athletic training to a client in a private gym would be subject to the provisions of the HCCA as would a member working in a hospital. A member who is conducting an assessment on behalf of an employer or insurance company should also seek the consent of the individual they are assessing. Despite the fact that a member may be hired by a company or insurance firm for the purposes of an assessment, the member enters into a therapeutic relationship with the person they are assessing and all standards of the profession, including the requirement for consent, apply. Consent in the health care context takes place between the practitioner and the patient/client. A third party cannot provide consent on behalf of the patient/client.

However, a member can delegate the consent discussion in certain circumstances, if appropriate. For example, an administrator of a facility might obtain consent for an assessment at an initial appointment on behalf of the member. The person conducting the consent discussion must be knowledgeable about the assessment and be able to answer any questions from the patient/client. However, the member retains the responsibility at all times of ensuring that there is valid and informed consent. If treatment involves a more invasive procedure or touching of a sensitive nature, the member should discuss and obtain consent from the patient/client directly.

Incapacity

There are situations in which a patient/client may not be able to provide informed consent because they are incapacitated. The HCCA sets out rules with respect to obtaining consent from the Substitute Decision Maker (SDM), while still including the patient/client as much as possible. Making a determination that someone is incapacitated for the purposes of consent is a very serious matter and goes to the very heart of an individual's autonomy and dignity.

The HCCA states that a person is capable with respect to a treatment if the person is able to understand the information that is relevant to making a decision about the treatment and is able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

All persons are presumed to be capable. A member may not presume that a person is incapable solely on the basis of any one of the following reasons:

- The existence of a psychiatric or neurological diagnosis;
- A refusal of a proposed service that is contrary to the member's advice or the advice of another practitioner;
- A request for an alternative service;
- The person's age;
- The existence of a disability, such as a hearing impairment; and/or
- The mere fact that a SDM is in place.

A patient/client may be in a situation that impedes their ability to process or understand information, but is still capable of providing consent. For example, where a patient/client has a hearing impairment, it is the duty of the member to ensure the patient/client receives all the information necessary to provide informed consent. The member might adjust the volume of his/her voice, move to a quieter setting or use a different method of communication, such as pen and paper.

The HCCA, as well as PHIPA, also explicitly state that a patient's/client's incapacity with respect to one matter may not necessarily mean that they are incapable to make other decisions. For example,

a patient/client may be able to consent to an initial assessment, but may not be able to consent to a treatment plan because they are unable to understand the more complex information provided with respect to the treatment. Also, a patient/client may be incapable at one time and capable at another time with respect to treatment. When a client is deemed to be capable again, consent must be sought from the patient/client.

If a patient/client was judged to be incapable and a SDM provided consent and the patient/client later becomes capable again, then the patient/client's/client's own decision to give or refuse consent governs.

How to assess capacity

A member may use the following observations as possible indicators of incapacity:

- The person shows evidence of confused or delusional thinking;
- The person appears unable to make a settled choice about service;
- The person is experiencing severe pain or acute fear or anxiety;
- The person appears to be severely depressed;
- The person appears to be impaired by alcohol or drugs; and/or
- Any other observations which give rise to a concern about the person's capacity, including the person's behaviour or communication.

What to do when a determination of incapacity is made

Under s.17 of the HCCA, it is mandated that the College set out guidelines to its members regarding the type of information that must be provided at a minimum to a patient/client about the consequences of a finding of incapacity. The College recommends the following courses of action following a finding of incapacity:

- Inform the patient/client that the member believes that the patient/client is incapable of providing consent to the proposed treatment unless:
 - there is a substantial risk of serious harm to the patient/client or another individual if the member informs the patient/client; or
 - the patient's/client's incapacity is to such a degree that they would be unable to understand the fact of the finding or the member's reasoning;
- Inform the patient/client that he/she may still be able to consent to other matters if he/she is deemed capable with respect to those matters;
- Inform the patient/client that an SDM will be responsible for making decisions on the patient's/client's behalf and the name of the SDM;
- Inform the patient/client of his/her right to appeal the finding to the Consent and Capacity Review Board (CCRB);
- If the patient/client objects to the particular SDM, the member should inform the patient/client that another person can be appointed by the CCRB;
- Inform the patient/client that his/her incapacity will continue to be reassessed and when capacity returns, he/she will be able to consent to treatment;
- Provide the information to the patient/client in a manner that the patient/client is best able to understand; for example, using simple language or providing a written information sheet; and/or
- Inform the patient/client that the finding of incapacity will be documented in the patient's/client's health record. The member must document the discussion thoroughly in the patient's/client's record

If a patient/client has indicated to the member that they plan to appeal the member's decision to the CCRB, then the member must not begin treatment.

Substitute decision makers

When a patient/client is deemed to be incapable of providing informed consent, the member must seek consent from a Substitute Decision Maker (SDM). The hierarchy of substitute decision makers is as follows:

1. Guardian
2. Attorney for personal care
3. A representative appointed by the Consent and Capacity Review Board
4. Spouse or partner (including a same-sex spouse)
5. Child, parent or children's aid society. This does not apply to a parent who has only a right of access
6. Parent with right of access only
7. A brother or sister
8. Any other relative
9. The Public Guardian and Trustee

The stipulations of the HCCA, the College's Practice Standard on Consent and this Guideline all apply to obtaining consent from the SDM.

In order to qualify as a substitute decision maker, a person must meet all of the following criteria:

- Be capable to consent to the treatment;
- Be at least 16 years old. The only exception is if the person under 16 is the incapable person's parent;
- Not be prohibited by a court order or separation agreement from having access to the incapable person or from giving or refusing consent on the incapable person's behalf;
- Be available; and
- Be willing to assume the responsibility of giving or refusing consent.

A SDM must make decisions on behalf of the patient/client that are in accordance with the patient's/client's known wishes or that are in the patient's/client's best interests. The HCCA outlines the factors that a SDM should take into account before making a decision on behalf of the patient/client. If the member does not believe that the SDM is acting in the best interests of the patient/client, the member can make an application to the CCRB.

Emergency treatment

Members cannot make decisions about a patient's/client's treatment without their consent except in certain emergency situations. An emergency situation is defined in the HCCA as when a person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm. Where practicable, consent should still be sought from the patient/client or his/her SDM, but not if the delay required in obtaining consent would prolong the suffering or put the person at risk of serious bodily harm. In the case of a person who is capable of providing consent but cannot do so due to a language barrier or disability, the member should attempt to find a way to communicate with that person and obtain consent. If the member is unable to communicate with the person and there is no reason to believe

that the person does not want the treatment, then the member can perform emergency treatment without consent.

For example, if a member is supervising a patient's/client's athletic program and the patient/client collapses from an apparent heart attack, the member should ascertain whether the patient/client is conscious and capable of providing consent. If the member determines that the patient/client is incapable of providing consent and no SDM is available, the member should proceed to provide CPR or other appropriate treatment, as may be required.

The member should document any treatment provided in an emergency in the patient's/client's health record as soon as possible. Consent should be sought as soon as possible from either the patient/client or SDM after the emergency treatment has been administered.

It is expected that emergencies in the kinesiology context would be rare.

Suggested Other Reading

Practice Standard- Code of Ethics

Practice Standard- Record Keeping

Practice Guideline- Privacy and Confidentiality of Personal Health Information

Practice Guideline- The Therapeutic Relationship and the Prevention of Sexual Abuse

Appendix 1

Sample Consent Form (this consent form is only a guide and should be modified as necessary to a practitioner's individual circumstances)

Consent to Treatment – Form

I, _____, hereby consent to the following treatment:
(Client's name or name of substitute decision maker)

(Describe the treatment in specific but understandable words for the client)

I have been told about the following:

- ☐ What the treatment is
- ☐ Who will be providing the treatment and for approximately how long
- ☐ The cost of the treatment
- ☐ The potential benefits of the treatment
- ☐ The potential risks and side-effects of the treatment
- ☐ The alternatives to having the treatment
- ☐ The potential risks of not having the treatment

I have understood the explanation and I have had the opportunity to ask questions.

I have been told that I may withdraw my consent to treatment at any time or ask for a reassessment.

My consent is given voluntarily.

Date

(Signature of patient/client)

(Print name of patient/client)

(Signature of Witness)

(Print name of witness)

Appendix K



Practice Standard- Code of Ethics

Definition

The ability to make appropriate ethical decisions that are in the best interests of patients/clients is an essential aspect of professional practice.

Overview

Members are responsible for conducting themselves as ethically as possible in every professional practice situation. To assist members in determining the most appropriate ethical conduct in situations of uncertainty, the College has adopted a values-based Code of Ethics and a stepwise decision-making model.

The Code of Ethics reflects members' commitment to use their knowledge and expertise to promote high quality, competent and ethical care for patients/clients and thereby instill public confidence in the profession.

The ethical values for members should be applied in all aspects of professional practice, particularly in the patient/client relationship and when facing an ethical problem or dilemma. Making ethical decisions is not always easy and can be accompanied by significant discomfort. While the Code of Ethics cannot alleviate this discomfort, adopting the values and a standard process to analyze a situation will allow members to feel more secure in their ability to make the best decision possible that is also in the best interest of their patients.

There are a variety of ethical decision making models available and although one version is presented here, members should choose a model that is most comfortable to them and meets their professional needs. Members should also understand that while a consistent process can be followed each time an ethical decision is required, the decision or outcome can vary because the context in which the decision is being made varies. There can be differences of opinion and it is not expected that there will always be complete agreement. The proposed actions to an ethical dilemma can include both those who are in favour and those who are opposed to the decision. Although there may not be complete agreement on one unique line of action, some actions will be more defensible and others will be less defensible. Following a consistent and reasoned process to ethical decision making will, however, increase the likelihood that even those opposed to the decision will respect it.

Principles of Ethical Conduct

Respect

Members are respectful of the differing needs of each individual and honour the patient's right to privacy, confidentiality, dignity and treatment without discrimination.

Excellence

Members are committed to excellence in professional practice through continued development of knowledge, skills, judgment and attitudes.

Autonomy and Well Being

Members are at all times guided by a concern for the patient's well-being. Patients have the right to self-determination and are empowered to participate in decisions about their health-related quality of life and physical functioning.

Communication, Collaboration and Advocacy

Members value the contribution of all individuals involved in the care of a patient. Communication, collaboration and advocacy are essential to achieve the best possible outcomes.

Honesty and Integrity

Each member's commitment to act with honesty and integrity is fundamental to the delivery of high quality, safe and professional services.

Steps to Ethical Decision-Making

1. Recognize that there is an ethical issue- I.e. something is making you uncomfortable.
2. Identify the problem and who is involved- What is making you uncomfortable? Who else is involved?
3. Consider the relevant facts, laws, principles and values- What laws or standards might apply? What ethical value or ethical principle is involved?
4. Establish and analyze potential options- Weigh possibilities and outcomes. Use your moral imagination.
5. After undertaking Steps 1 through 4, choose a course of action and implement it- Are there any barriers to action? What information should be recorded?
6. Evaluate the outcome and determine if further action is needed- What did you learn? What can you do to prevent future occurrence?